

Summary Plan Description
United HealthCare Choice Plan
for
the State Health Benefit Plan

Group Number: 702030
Effective Date: January 1, 2009

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Outpatient Prescription Drug Rider 1

Introduction

This booklet is your Summary Plan Description (SPD) and describes the provisions of your State Health Benefit Plan (SHBP), which is also referred to in this booklet as the “Plan.” Use this SPD as a reference tool to help you understand the Plan and maximize your coverage.

The SHBP is a self insured Plan, which is governed by the regulations of the Department of Community Health (DCH) Board, Chapter 111-4-1 Health Benefit Plan. If there are discrepancies between the information in this SPD and DCH Board regulations or the laws of the state of Georgia, those regulations and laws will govern at all times.

This booklet is notice to all members of the SHBP’s eligibility requirements and benefits payable for services provided on or after January 1, 2009, unless otherwise noted. Any and all statements to Members or to Providers about eligibility, payment or levels of payment that were made before January 1, 2009 are canceled if they conflict in any way with the provisions described in this booklet.

The SHBP reserves the right to act as sole interpreter of all the terms and conditions of the Plan, including this booklet and the separate medical policy guidelines that serve as supplement to this booklet to more fully define eligible charges.

The SHBP also reserves the right to modify its benefits, level of benefit coverage and eligibility/participation requirements at any time, subject only to reasonable notification to Members. When such a change is made, it will apply as of the modification’s effective date to any and all charges incurred by Members on that day and after, unless otherwise specified by the DCH.

The Summary Plan Description published by United HealthCare for members enrolled in the SHBP does not constitute a contract. The provisions of the program are subject to annual review and modification. Costs may vary each year.

How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this SPD by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read (Section 10: General Legal Provisions) to better understand how this SPD and your Benefits work. You should call United HealthCare if you have questions about the limits of the coverage available to you.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your SPD and any attachments in a safe place for your future reference.

Please be aware that your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 11: Glossary of Defined Terms). You can refer to Section 11 as you read this document to have a clearer understanding of your SPD.

When we use the words "we", "us", and "our" in this document, we are referring to the State Health Benefit Plan (SHBP). When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 11: Glossary of Defined Terms).

Fraud and Abuse

Please notify the Plan of any fraudulent activity regarding Plan members, providers, payment of benefits, etc. Call 1-866-242-7727.

Your Contribution to the Benefit Costs

The Plan may require the Member to contribute to the cost of coverage. Contact your benefits representative for information about any part of this cost you may be responsible for paying.

Customer Service and Claims Submittal

Please make note of the following information that contains United HealthCare department names and telephone numbers.

Customer Service Representative (questions regarding Coverage or procedures), 1-866-527-9599, as shown on your ID card.

Prior Notification/Care Coordination: 1-866-527-9599

For detailed explanation on Prior Notification please see page 5.

Mental Health/Substance Abuse Services: 1-866-527-9599

Pharmacy Questions: 1-866-527-9599

Plan's Eligibility Unit: 404-656-6322, Atlanta

800-610-1863, toll-free outside Atlanta

Monday-Friday, 8:30 a.m. to 4:30 p.m.

Membership Correspondence for non-claim/eligibility issues:
State Health Benefit Plan

Membership Correspondence Unit

P.O. Box 1990, Atlanta, GA 30301

Note: For forms and procedures related to these appeals go to www.dch.georgia.gov/shbp_plans

Claims Submittal Address:

United HealthCare Insurance Company

Attn: Claims

PO Box 740806

Atlanta, Georgia 30374-0800

**Submit requests for Review of Denied Claims/Appeals and
Notice of Complaints to:**

United HealthCare Insurance Company

PO Box 30994

Salt Lake City, Utah 84130-0994

**Note: SHBP reserves the right to request medical records and
any other supporting documentation for medical and
pharmacy claims submitted.**

Section 1:

What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits (Refer to Section 1 “What’s Covered—Benefits and Section 2 “What’s Not Covered--Exclusions)
- Copayment/Coinsurance and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you or your provider to notify United HealthCare before you receive them. In general, Network providers are responsible for notifying United HealthCare before they provide certain health services to you.

Accessing Benefits

You must see a Network Physician to obtain Benefits for covered health services. For details, see (Section 3: Obtaining Benefits). You must show your identification (ID) card every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you

are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 9: Continuation of Coverage under COBRA) occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Copayment/Coinsurance

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment/Coinsurance, see (Section 11: Glossary of Defined Terms). Copayment/Coinsurance amounts are listed on the following pages next to the description for each Covered Health Service. Please note that Copayments are calculated as a set dollar amount. Coinsurance is a percentage based on Eligible Expenses.

Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by us or by our designee. In almost all cases, our designee is United HealthCare. For a complete definition of Eligible Expenses that describes how payment is determined, see (Section 11: Glossary of Defined Terms).

We have delegated to United HealthCare the discretion and authority to determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

When you receive Covered Health Services from Network providers, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills.

Notification Requirements

In general, Network providers are responsible for notifying United HealthCare before they provide services to you. There are some Benefits, however, for which you are responsible for notifying United HealthCare. Please refer to the **Benefit Information** section for additional notification requirements.

Special Note Regarding Medicare

Prior approval is required for transplant services, Skilled Nursing admissions and home intravenous medication therapy, even if Medicare is primary, and for expenses that Medicare does not cover. You should call United Behavioral Health whenever you need mental health and substance abuse care, even if you have primary coverage through Medicare or a health plan other than SHBP.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 11: Glossary of Defined Terms). The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. For a complete definition of Eligible Expenses, see (Section 11: Glossary of Defined Terms).	<u>Active</u> Employee Deductible-\$400 Employee & Spouse Deductible -\$600 Employee & Child(ren) Deductible -\$600 Employee, Child(ren) & Spouse Deductible-\$800
		<u>Retiree</u> Single Deductible-\$400 Family Deductible-\$800
Out-of-Pocket Maximum	The maximum you pay for Covered Health Services in a Plan year for Coinsurance and Annual Deductible. For a complete definition of Out-of-Pocket Maximum, see (Section 11: Glossary of Defined Terms). The Out-of-Pocket Maximum does include the Annual Deductible. Copayment amounts are excluded from the Out-of-Pocket Maximum.	<u>Active</u> Employee Out-of-Pocket -\$1,500 plus Copayments Employee & Spouse Out-of-Pocket -\$2,250 plus Copayments Employee & Child(ren) Out-of-Pocket - \$2,250 plus Copayments Employee, Child(ren) & Spouse Out-of-Pocket -\$3,000 plus Copayments
		<u>Retiree</u> Single Out-of-Pocket -\$1,500 plus Copayments Family Out-of-Pocket -\$3,000 plus Copayments

Payment Term	Description	Amounts
Lifetime Maximum Benefit	The maximum amount we will pay for Covered Health Services during the entire period of time you are enrolled under the State Health Benefit Plan (SHBP). For a complete definition of Lifetime Maximum Benefit, see (Section 11: Glossary of Defined Terms).	\$2,000,000 per Covered Person (combined for all SHBP options)

Benefit Information

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. Non-emergency transportation ground or air transportation of covered member to or from a medical facility, Physician's office, or patient's home is excluded, unless approved by Care Coordination.	<i>Ground Transportation:</i> 0% <i>Air Transportation:</i> 0%	NA/NA	No

2. Dental Services and Oral Care Surgery:

Notify United HealthCare

Please notify United HealthCare at the telephone number on your ID (1-866-527-9599) card as soon as possible, but at least five business days before follow-up (post Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment).

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
A. Accident only			
Certain dental services when all of the following are true:			
<ul style="list-style-type: none"> • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.". • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. 	Inpatient and Outpatient facility charges 10%	NA/Yes	Yes
Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:	Office Visit Copayment \$30	No/NA	No
<ul style="list-style-type: none"> • A sound and natural or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. 			
Dental services for final treatment to repair the damage must be both of the following:			
<ul style="list-style-type: none"> • Started within three months of the accident. • Completed within 36 months of the accident. 			
(Benefit information continued on next page)			

**Description of
Covered Health Service**

**Your
Copayment/
Coinsurance
Amount**
% Co-insurance are
based on a percent of
Eligible Expenses

**Does
Copayment/
Coinsurance
Help Meet
Out-of-Pocket
Maximum?**

**Do You Need
to Meet Annual
Deductible?**

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

B. Oral Care

The Plan will consider coverage only for:

- Prompt Repair of natural teeth or tissue in connection with reconstructive surgical procedures following treatment of oral cancer or other covered diagnoses.
- Surgery to treat lesions of the mouth, lip or tongue, if the lesion requires a pathological examination,
- Surgery (frenulectomy) for treatment of a child's speech impairment, when medically indicated,
- Surgery of accessory sinuses, salivary glands or ducts, surgery to repair cleft palates,
- Orthognathic surgery to correct obstructive sleep apnea and for dependents age 19 and under born with specific craniofacial syndromes, and

Inpatient and
Outpatient
facility charges
10%

NA/Yes

Yes

Oral surgery in
an office
\$30 Copayment

No/NA

No

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Institutional and anesthesia charges associated with a non-covered dental care normally performed in a dental office, but due to the patient's medical condition, care in a Hospital setting is warranted, as required under State Law. <p>Repairs that are not performed promptly (as defined) will be denied unless a compelling medical reason exists. X-Rays and other documentation may be required to determine benefit coverage.</p>			
C. Temporomandibular Joint Dysfunction (TMJ)			
<p>Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Benefits include necessary diagnostic or surgical treatment required as a result of accident, trauma, congenial defect, developmental defect, or pathology.</p>	<p>Inpatient and Outpatient facility charges 10%</p>	<p>NA/Yes</p>	<p>Yes</p>
<p>Benefits are not available for charges or services that are dental in nature, including appliances and orthodontic care.</p>	<p>Office visit Copayment \$30</p>	<p>No/NA</p>	<p>No</p>
D. Wisdom Teeth (Fully Impacted Only)			
<p>Fully Impacted wisdom teeth are covered under the medical plan.</p>	<p>\$30 Copayment per visit</p>	<p>No/NA</p>	<p>No</p>

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?	
<div>3. Durable Medical Equipment</div> <div><div>Notify United HealthCare</div><div>Please remember that you must notify United HealthCare before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item). If you don't notify United HealthCare, you will be responsible for paying all charges and no Benefits will be paid. Contact Care Coordination to determine if equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor Care Coordination identifies.</div></div>	<div>Notify United HealthCare for items more than \$1,000.</div>	<div>0%</div>	<div>NA/NA</div>	<div>No</div>
<div>Durable Medical Equipment (DME) that meets each of the following criteria:</div> <div><div><div><div>• Ordered or provided by a Physician for outpatient use.</div><div>• Used for medical purposes.</div><div>• Not consumable or disposable, except urinary catheters and ostomy supplies.</div><div>• Disposable items that are considered an integral part of covered DME.</div><div>• Not of use to a person in the absence of a disease or disability.</div></div></div></div>				
<div>(Benefit information continued on next page)</div>				

**Description of
Covered Health Service**

**Your
Copayment/
Coinsurance
Amount**
% Co-insurance are
based on a percent of
Eligible Expenses

**Does
Copayment/
Coinsurance
Help Meet
Out-of-Pocket
Maximum?**

**Do You Need
to Meet Annual
Deductible?**

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost effective piece of equipment.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a wheelchair or scooter.
- A standard Hospital type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service.
- Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air conditions, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage). <p>We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every Plan year.</p> <p>United HealthCare will determine if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor United HealthCare identifies.</p>			
<h3>4. Emergency Health Services</h3> <p>Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).</p>	\$100 Copayment per visit	No/NA	No

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
5. Eye Examinations Medical Eye examinations received from a health care provider, for diagnosis and treatment of eye condition. NOTE: We will cover eyeglasses or contact lenses (first pair only) after cataract surgery.	\$30 Copayment per visit	No/NA	No
Routine Network routine eye exam benefits received from a health care provider. Network benefits include one routine vision exam, including refraction, to detect vision impairment by a Contracted provider, limited to one every 24 months. Routine eye exams are not subject to the deductible. Vision Discount program available through United Health Wellness 1-800-860-8773.	A \$200 benefit per Plan year for combination of glasses and/or contacts.		

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<h2>6. Home Health Care</h2> <p>Services received from a Home Health Agency that are both of the following:</p> <ul style="list-style-type: none"> • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. <p>Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Up to four hours of skilled care services. Benefit limit to 120 visits per Plan year.</p> <p>Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:</p> <ul style="list-style-type: none"> • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician. • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair. <p>(Benefit information continued on next page)</p>	0%	NA/NA	No

Description of Covered Health Service	Your Copayment/Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> It requires clinical training in order to be delivered safely and effectively. It is not Custodial Care. <p>United HealthCare will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.</p>			
<h2>7. Hospice Care</h2> <p>Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency.</p> <p>Please contact United HealthCare for more information regarding guidelines for hospice care. You can contact United HealthCare at the telephone number on your ID card.</p> <p>Benefits are limited to 360 days during the entire period of time you are covered under the Plan.</p> <p>Benefits for bereavement are limited to 8 visits per Plan year.</p>	0%	NA/NA	Yes

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
8. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: <ul style="list-style-type: none"> Services and supplies received during the Inpatient Stay. Room and board in a Semi-private Room (a room with two or more beds). Acute Inpatient Rehabilitation. Benefits for Physician services are described under <i>Professional Fees for Surgical and Medical Services</i> .	10%	NA/Yes	Yes
9. Infertility Services Services for the treatment of infertility (for underlying medical condition only) when provided by or under the direction of a Network Physician. We will cover diagnostic testing to rule out a diagnosis, but once diagnosed treatment of infertility services is not covered. Please also refer to Section 2: What's Not Covered -- Exclusions under item L. Reproduction.	10%	NA/Yes	Yes

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
10. Injections received in a Physician's Office	0% per injection	NA/NA	No
Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	\$30 Copayment per visit	No/NA	No
11. Maternity Services (prenatal, delivery and postpartum)	0% after initial \$30 Copayment	No/NA	No
Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity related medical services for prenatal care, postnatal care, delivery, and any related complications.	Newborn Wellness: 0%	NA/NA	No
There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify United HealthCare during the first trimester, but no later than one month prior to the anticipated delivery date.			

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>We will pay for an Inpatient Stay of at least:</p> <ul style="list-style-type: none"> • According to Federally Mandated Guidelines we will pay 48 hours for the mother and newborn child following a normal vaginal delivery. • According to Federally Mandated Guidelines we will pay 96 hours for the mother and newborn child following a cesarean delivery. <p>If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.</p>			

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
12. Mental Health and Substance Abuse Services - Outpatient			
<p>Please remember that you must call United Behavioral Health (UBH) and get authorization to receive these Benefits in advance of any treatment. The UBH phone number that appears on your ID card is 1-866-527-9599.</p>	<p>\$30 Copayment per individual visit</p>	<p>No/NA</p>	<p>No</p>
<p>Please contact UBH prior to receiving services to verify you are using a UBH provider – no benefits will be paid if a UBH provider is not used.</p>	<p>\$10 Copayment per group visit</p>	<p>No/NA</p>	<p>No</p>
<p>Without authorization, you will be responsible for paying all charges and no Benefits will be paid.</p>			
<p>Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:</p>			
<ul style="list-style-type: none"> • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). 			

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
13. Mental Health and Substance Abuse Services - Inpatient and Intermediate	10%	NA/Yes	No
<p style="text-align: center;">Notify United HealthCare For Authorization</p> <p>Please remember that you must call United Behavioral Health (UBH) and get authorization to receive these Benefits in advance of any treatment. The UBH phone number that appears on your ID card is 1-800-396-6515.</p> <p>For all admissions, including urgent/emergent: within one business day or the same day of admission, or as soon as is reasonably possible.</p> <p>United Behavioral Health (UBH), who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</p> <p>Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of UBH. For Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of UBH, who is responsible for coordinating all of your care. Contact the UBH regarding Benefits</p> <p>(Benefit information continued on next page)</p>			

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>for inpatient/intermediate Mental Health Services and Substance Abuse Services. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. Services on an inpatient medical unit for acute detoxification are covered under the medical in-patient benefit.</p>			
<p>Professional Charges Inpatient Benefits are limited to 1 visit per authorized day combined per Plan year.</p>			

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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14. Nutritional Counseling

Covered Health Services provided by an approved provider such as a registered or licensed dietician/ nutritionist in an individual or group session for Covered Persons with medical conditions that require a special diet. Examples of such medical conditions include, but are not limited to:

- Diabetes mellitus.
- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout.
- Renal failure.
- Phenylketonuria.
- Hyperlipidemias.
- Eating Disorders.

Benefits are limited to three individual or group sessions during a Covered Person's lifetime for each medical condition.

0%

NA/NA

No

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
15. Ostomy and Urinary Catheter Supplies Benefits for ostomy supplies include only the following: <ul style="list-style-type: none"> • Pouches, face plates and belts. • Irrigation sleeves, bags and catheters. • Skin barriers. • Urinary Catheters. Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.	0%	NA	No

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Outpatient Surgery, Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:	10%	NA/Yes	Yes
<ul style="list-style-type: none"> • Surgery and related services. • Non-routine lab and radiology/X-ray. (For routine lab and radiology/X-ray see Physician's Office Services). • Non-routine mammography testing. (For routine mammography testing see Physician's Office Services). • Other diagnostic tests and therapeutic treatments (including cancer) chemotherapy or intravenous infusion therapy. 	<i>For mammography testing:</i> Non-routine: 10%	NA/Yes	Yes
Benefits under this section include only the facility charge, the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under Professional Fees for Surgical and Medical Services.			

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
17. Physician's Office Services – Wellness Care/Preventative Healthcare and Annual Gynecological Exams	\$30 Copayment per PCP visit	No/NA	No
Covered Health Services for preventive wellness care includes:	\$30 Copayment per Specialist visit	No/NA	
<ul style="list-style-type: none"> Well-baby and well-child care. 	No Copayment		
<ul style="list-style-type: none"> Routine physical examinations. 	applies when no		
<ul style="list-style-type: none"> Vision and hearing screenings. 	Physician charge is assessed		
<ul style="list-style-type: none"> Immunizations. 			
<ul style="list-style-type: none"> Routine Mammograms. 	Expenses for routine mammograms		
<ul style="list-style-type: none"> Routine lab/X-ray. 	0%, regardless of		
<ul style="list-style-type: none"> Routine colonoscopy screenings for colorectal cancer for persons 50 or older. 	place of service		
	0% for preventive medical services and all related services, except for the office visit charge which is subject to the office visit Copayment		

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Physician's Office Services - Medical Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.	\$30 Copayment per PCP visit \$30 Copayment per Specialist visit No Copayment applies when no Physician charge is assessed.	No/NA No/NA	No
18. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls. When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above.	10%	No/Yes	Yes

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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19. Prosthetic Devices

0%

NA

No

External prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.
- Cochlear implants are covered but are subject to prior approval.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every Plan year.

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Except for items required by the Women's Health and Cancer Rights Act of 1998, any combination of Network and Non-Network Benefits for prosthetic devices is limited to \$50,000 per Plan year. This limit applies to the total amount that we will pay for prosthetic devices and does not include any Coinsurance or Annual Deductible responsibility you may have. NOTE: Subject to a 2 - 3 year limitation and also subject to medical necessity.</p> <p>Once this Benefit limit is reached, no additional Benefits are available except for items required by the Women's Health and Cancer Rights Act of 1998.</p>			

Description of
Covered Health Service

Your
Copayment/
Coinsurance
Amount
% Co-insurance are
based on a percent of
Eligible Expenses

Does
Copayment/
Coinsurance
Help Meet
Out-of-Pocket
Maximum?

Do You Need
to Meet Annual
Deductible?

20. Reconstructive Procedures – Authorization Required

Authorization Required

Please remember that you must call (1-866-527-9599) and get authorization to receive these Benefits in advance of any treatment through the reconstructive procedures.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact United HealthCare at the telephone number on your ID card for more information about Benefits for mastectomy related services.

Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic, Therapeutic Services and Prosthetic Devices.

(Benefit information continued on next page)

**Description of
Covered Health Service**

**Your
Copayment/
Coinsurance
Amount**
% Co-insurance are
based on a percent of
Eligible Expenses

**Does
Copayment/
Coinsurance
Help Meet
Out-of-Pocket
Maximum?**

**Do You Need
to Meet Annual
Deductible?**

Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

NOTE: Breast reductions may or may not be considered cosmetic; therefore are subject to prior notification.

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
21. Rehabilitation Services - Outpatient Therapy	\$25 Copayment per visit	No/NA	No
<p>Short-term outpatient rehabilitation services for:</p> <ul style="list-style-type: none"> Physical therapy. (40 visits per Plan year). Occupational therapy. (40 visits per Plan year). Speech therapy. (40 visits per Plan year). Pulmonary rehabilitation therapy. (40 visits per Plan year). Cardiac rehabilitation therapy. (40 visits per Plan year). <p>Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.</p> <p>Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.</p>			

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>22. Skilled Nursing Facility</p> <p>Services for an Inpatient Stay in a Skilled Nursing Facility. Benefits are available for:</p> <ul style="list-style-type: none"> • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). <p>Benefits are limited to 120 days per Plan year.</p> <p>Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.</p>	10%	No/Yes	Yes
<p>23. Spinal Treatment, Chiropractic & Osteopathic Manipulative Therapy</p> <p>Benefits for Spinal Treatment when provided by a Network Spinal Treatment provider in the provider's office.</p> <p>Benefits include diagnosis and related services and are limited to one visit and treatment per day.</p> <p>Benefits for Spinal Treatment are limited to 20 visits per Plan year.</p>	\$30 Copayment per visit	No/NA	No

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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24. Transplantation Services

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact United HealthCare at the telephone number on your ID card for notification and information about these guidelines.

Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy.
- Cornea transplants (You are not required to notify United Resource Networks or Care Coordination of a cornea transplant nor is the cornea transplant required to be performed at a Designated United Resource Networks Facility).
- Heart transplants, lung transplants or heart/lung transplants.
- Kidney transplants, pancreas transplants or kidney/pancreas transplants.

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> • Liver transplants, small bowel transplants or liver/small bowel transplants. • Other transplants deemed appropriate by Care Coordination. <p>Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.</p>			
<p style="text-align: center;">Transportation and Lodging</p> <p>United HealthCare will assist the patient and family with travel and lodging arrangements when services are received from a Designated Facility. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:</p>	10%	NA/Yes	Yes
<ul style="list-style-type: none"> • Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up. • Eligible Expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people. • Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility. 			

(Benefit information continued on next page)

Description of Covered Health Service	Your Copayment/ Coinsurance Amount <small>% Co-insurance are based on a percent of Eligible Expenses</small>	Does Copayment/ Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the \$100 per diem rate. <p>There is a combined overall lifetime maximum Benefit of \$10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.</p>			
25. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, benefits are available as described under <i>Physician's Office Services</i> earlier in this section.	\$35 Copayment per visit	No/NA	No
26. Wigs Wigs are excluded regardless of the reason for the hair loss, with the exception of hair loss relating to cancer/chemotherapy treatment. There is a lifetime maximum of \$750 for wigs.	0%	NA/NA	Yes

Section 2: What's Not Covered-- Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. We call these Exclusions regardless of medical necessity. This section lists some (but not all) of the things the plan does not cover at all, under any circumstances.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following are true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in (Section 1: What's Covered--Benefits) or through a Rider to the SPD.

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Environmental Medicine services or homeopathic/holistic/alternative medicine services, including visits, diagnostic testing, labs, medication, or procedures.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.

5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners.
 - Air purifiers and filters.
 - Batteries and battery chargers.
 - Dehumidifiers.
 - Humidifiers.
6. Devices and computers to assist in communication.
7. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
8. Air cleaners and dust collection device.
9. Vacuum erection devices (VED, erect aid) to stimulate the penis.
10. Duplication, upgrade or replacement of currently function equipment.

C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
 - Extraction, partially impacted wisdom teeth, restoration and replacement of teeth.
 - Medical or surgical treatments of dental conditions.
 - Services to improve dental clinical outcomes.
3. Dental implants or associated services such as bone grafts for the placement of dental implants.
4. Dental braces and Orthodontics.

5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
 - Transplant preparation.
 - Initiation of immunosuppressives.
 - The direct treatment of acute traumatic Injury, cancer or cleft palate, except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly, including but not limited to Cleft Palate.
7. Alveoplasty; vestibuloplasty, apicoectomy; excision of mandibular tori or exostosis; occlusal devices or their adjustment; splints for bruxism (clenching or grinding of teeth).
8. Surgery, appliances or prostheses such as crown, bridges or dentures; fillings; endodontic care; treatment of dental caries; excision of radicular cysts or granuloma; treatment of periodontal disease; and associated charges with any non-covered or oral service or supply.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription.
2. Self-injectable medications.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over the counter drugs and treatments.

****Please refer to Outpatient Prescription Drug Rider.**

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

1. Routine foot care (including the cutting or removal of corns and calluses), with the exception of enrollees with diabetes or enrollees who are at risk of neurological or vascular diseases such as diabetes.
2. Nail trimming, cutting, or debriding, with the exception for diabetic foot care.
3. Hygienic and preventive maintenance foot care. Examples include the following:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.
 - Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
4. Treatment of flat feet, fallen arches and chronic foot strain.
5. Treatment of subluxation of the foot.
6. Foot care devices such as arch supports and orthotics (except for the diagnosis of diabetes).
7. Shoes and footwear of any kind (except for therapeutic diabetic shoes) unless permanently attached to a covered brace.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies (except when considered an integral part of covered Durable Medical Equipment). Examples include:
 - Ace bandages.
 - Gauze, dressings and tape.
 - Lubricants and saline solution.
 - Syringes.
 - Surgical masks and gloves.
 - Batteries and battery chargers.
 - Diabetic supplies, including but not limited to glucose monitors, test strips and lancets. **Please refer to Outpatient Prescription Drug Rider.
3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What's Covered--Benefits).
5. Hot and cold packs.
6. Breast pumps.
7. Blood pressure cuffs (unless related to dialysis).
8. Lift for scooters and wheelchairs, stair glides and elevators, and any other home modifications.
9. Devices and computers to assist in communication.
10. Vacuum erection devices (VED, erect aid) to stimulate the penis.
11. Duplication, upgrade or replacement of currently functioning equipment.

12. Repair or replacement of Durable Medical Equipment due to damages caused by misuse, malicious breakage or gross neglect.
13. Replacement of lost or stolen Durable Medical Equipment

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention and stabilization.
3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by UBH.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangement and any court ordered treatment unless medically necessary and unless authorized by UBH.

7. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of UBH, are any of the following:
 - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
 - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
 - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
 - Not consistent with UBH's level of care guidelines or best practices as modified from time to time.

UBH may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

8. Recreational, educational or bio-feedback therapy, unless specifically approved by UBH, or any form of self-care or self help training or related diagnostic testing.
9. Marriage counseling, unless approved in advance by UBH and conducted by a UBH authorized provider.
10. Pastoral counseling.
11. Services of a social worker, professional counselor, psychiatric nurse specialist or marriage and family therapist even if prescribed by a Physician, unless pre-authorized by UBH and conducted by a UBH network provider.

12. Smoking cessation programs.
13. Weight management programs not related to psychiatric condition.
14. Psychoanalysis, to complete degree or residency requirements.
15. Vocational or educational training/services and related psychological testing.
16. Hypnosis.
17. Any psychological testing not related to a mental health or substance abuse diagnosis.
18. Experimental treatment performed for research.
19. Therapy treatment for attention deficit disorders, except for diagnosis and medical management, learning disabilities, developmental delays (except as mandated by state law for treatment of autism) or for speech disorders (such as stuttering) not related to an acute illness.
20. Treatment of a condition resulting from mental retardation, academic skills disorder, developmental disorder (except for autism diagnosis and treatment as required by state law) or motor skills disorder.
21. Treatment of a condition classified by a UBH Provider as situational, and classified in DSM as a V-code ailment if there's no additional diagnosis to indicate a psychiatric ailment.
22. Family therapy when patient is not present.
23. Residential treatment, sub-Acute care; services of halfway house, supervised group home or boarding school.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups except as specifically described in (Section 1: What's Covered--Benefits).

3. Enteral Feeding and other nutritional and electrolyte supplements, including infant formula and donor breast milk (except when approved by Care Coordination).
4. Minerals or metabolic deficiency formulas (except when approved by Care Coordination).

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 11: Glossary of Defined Terms). Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss except for wigs required as a result of cancer.
6. Hair removal, including electrolysis.

6. Blepharoplasty (upper or lower eyelid), browplasty, brow lift (except when approved by Care Coordination).
7. Sclerotherapy and other related services (except when approved by Care Coordination).

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free standing or Hospital based diagnostic facility without an order written by a Physician or other provider. Services that are self directed to a free standing or Hospital based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free standing or Hospital based diagnostic facility, when that Physician or other provider:
 - Has not been actively involved in your medical care prior to ordering the service, or
 - Is not actively involved in your medical care after the service is received.

L. Reproduction

1. In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures and any other reproductive technology.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Infertility monitoring, correction or treatment.
5. Storage of egg, sperm or blood product for future use.

6. Infertility drugs and reproductive medicines.

M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services and expenses for transplants involving artificial, mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility.

5. Any solid organ transplant that is performed as a treatment for cancer.
6. Any multiple organ transplants not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered--Benefits).
7. Lodging related to, except as defined in (Section 1: What's Covered --Benefits *Transplantation Services*) the donation or transplantation of an organ.
8. Transplant therapy used as a palliative procedure. Transplant therapy considered experimental.
9. Some travel expenses related to covered transplantation services may be reimbursed as outlined in the Transplantation Service Section.

O. Travel

1. Travel or transportation expenses, even though prescribed by a Physician.

P. Vision and Hearing

1. Purchase cost of hearing aids.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. Eye exercise therapy and/or orthoptic training.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery, including LASIK.
5. Diagnosis, treatment or surgical and non-surgical correction of far-sightedness, near-sightedness or astigmatism. Any vision care, including low-vision and other vision aids.
6. Tinnitus therapy, including sound generators.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 11: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
 - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research.
 - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature.

8. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
9. Medical and surgical treatment of obesity/morbid obesity including, but not limited to, bariatric surgical procedures, gastric restrictive procedures, gastric bypass procedures, weight reduction surgery and revisions. Non-surgical treatment of obesity/morbid obesity, for example Optifast, Weight Watchers, Jenny Craig, etc. Panniculectomy, abdominoplasty, repair of diastasis recti, tummy tuck, excision of excessive skin and/or subcutaneous tissue, and liposuction.
10. Growth hormone therapy.
11. Sex transformation operations.
12. Custodial Care.
13. Domiciliary care.
14. Private duty nursing.
15. Respite care.
16. Rest cures.
17. Psychosurgery.
18. Treatment of benign gynecomastia (abnormal breast enlargement in males).
19. Medical and surgical treatment of excessive sweating (hyperhidrosis).
20. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
21. Oral appliances for snoring.
22. Inpatient therapies such as rehabilitation, rehabilitative therapy or restorative therapy, unless significant improvement is expected within a reasonable and generally predictable period of time following an acute illness.
23. Transitional living programs, day treatment programs related to senior/adult care treatment, assisted living, non-skilled assisted care, nursing homes, personal care homes, extended care facilities, cognitive remediation therapy.
24. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, a Congenital Anomaly, or as mandated by state law for treatment of autism.
25. Any charges for missed appointments, room or facility, reservations, completion of claim forms or record processing.
26. Any charge for services, supplies or equipment advertised by the provider as free.
27. Any charges prohibited by federal anti-kickback or self-referral statutes.

Section 3: Obtaining Benefits

This section includes information about:

- Obtaining Benefits.
- Provider Network
- Emergency Health Services.

Benefits

Benefits are payable for Covered Health Services which are any of the following:

- Provided by or under the direction of a Network Physician or other Network provider in the Physician's office or at a Network facility.
- Emergency Health Services.
- Urgent Care Center services received outside the service area.

Benefits are not payable for Covered Health Services that are provided by non-Network providers.

Please note that Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. Please see (Section 1: What's Covered--Benefits) under the heading for *Mental Health and Substance Abuse*.

Provider Network

United HealthCare arranges for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees or employees of United HealthCare. It is your responsibility to select your provider.

The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Upon request, a Provider directory is available for you. However, before obtaining services you should always verify the Network for status of a provider. A provider's status may change. You can verify the provider's status by calling United HealthCare or by referring to www.myuhc.com.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some products. Refer to your provider directory, contact United HealthCare for assistance or access www.myuhc.com website.

Care CoordinationSM

Your Network Physician is required to notify United HealthCare regarding certain proposed or scheduled health services. When your Network Physician notifies United HealthCare, they will work together to implement the Care CoordinationSM process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

If you receive certain Covered Health Services from a Network provider, you must notify United HealthCare. The Covered Health Services for which notification is required is shown in (Section 1: What's Covered--Benefits). When you notify United HealthCare, you will be provided with the Care Coordination services described above.

Designated Facilities and Other Providers

If you have a medical condition that United HealthCare believes needs special services, they may direct you to a Designated Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, United HealthCare may direct you to a non-Network facility or provider.

In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility or other provider chosen by United HealthCare.

You or your Network Physician must notify United HealthCare of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network facility or provider. If you do not notify United HealthCare in advance and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

Benefits for Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify United HealthCare, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, we will pay Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Limitations on Selection of Providers

If United HealthCare determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, United HealthCare will select a single Network Physician for you. If you fail to use the selected Network Physician, Benefits for Covered Health Services will not be paid.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician. Non-Emergency use of the Emergency Room is not covered.

Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, United HealthCare must be notified within one business day or on the same day of admission if reasonably possible. United HealthCare may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date United HealthCare decides a transfer is medically appropriate, Benefits will not be available.

True Emergency Eligible Medical Services rendered outside of United States are covered subject to plan guidelines. Non-emergency services are not covered. All foreign claims and medical records are subject to medical review and should be submitted to United Health Group International at Claims P.O. 740817 Atlanta, GA 30374.

International Claim form can be obtained at www.myuhc.com/groups/gdch.

Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person should contact his or her Payroll location for instructions on enrolling within 31 days of hire. SHBP will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, SHBP will pay Benefits from the day coverage begins for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify United HealthCare within 48 hours of the day your coverage begins, or as soon as reasonably possible. In-Network Benefits are available only if you receive Covered Health Services from Contracted providers.

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	<p>You are eligible to enroll yourself and your eligible dependents for coverage if you are:</p> <ul style="list-style-type: none"> • A Full-time employee of the State of Georgia, the General Assembly or an agency, board, commission, department, county administration or contracted employer that participates in SHBP, as long as: <ul style="list-style-type: none"> — You work at least 30 hours a week consistently, and — Your employment is expected to last at least nine months. <p>Not Eligible: Student employees or seasonal, part-time or short-term employees.</p> • A certified public school teacher or library employee who works half-time or more, but not less than 17.5 hours a week. <p>Not Eligible: Temporary or emergency employees.</p> • A non-certified service employee of a local school system who is eligible to participate in the Teachers Retirement System or its local equivalent. You must also work at least 60% of a standard schedule for your position, but not less than 20 hours a week. • An employee who is eligible to participate in the Public School Employees' Retirement System as defined by Paragraph 20 of Section 47-4-2 of the Official Code of Georgia, Annotated. You must also work at least 60% of a standard schedule for your position, but not less than 15 hours a week. 	SHBP determines who is eligible to enroll under the Plan.

Who	Description	Who Determines Eligibility
	<ul style="list-style-type: none"> • A retired employee of one of these listed groups who was enrolled in the Plan at retirement and is eligible to receive an annuity benefit from a state sponsored or state related retirement system. See Provisions for Eligible Retirees for details of retiree medical coverage. • An employee in other groups as defined by law. 	
Dependent	<p>Eligible dependents are:</p> <ul style="list-style-type: none"> • Your legally married spouse; as defined by Georgia law. • Your never married dependent children who are: <ul style="list-style-type: none"> (1) Natural or legally adopted children under age 19, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody. (2) Stepchildren under age 19 who live with you at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents. (3) Other children under 19 if they live with you permanently and legally depend on you for financial support – as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction. (4) Your natural children, legally adopted children or stepchildren 19 or older from categories 1, 2 and 3 above who are physically or mentally disabled prior to age 26 and who depend on you for primary support. 	SHBP determines who qualifies as a Dependent.

Who	Description	Who Determines Eligibility
	<p>(5) Your natural children, legally adopted children, stepchildren or other children age 19 to 26 from categories 1, 2 and 3 above who are registered Full-time Students at fully accredited schools, colleges, universities, or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for Full-time Student status is defined by the school in which the child is enrolled. You have 31 days from the date of your child's enrollment as a full-time student to add dependent coverage.</p> <p>You must also provide a completed <i>Dependent Student Status Information form</i> and Full-time Student Verification from a fully accredited school, college, university, or nurse training institution.</p> <p>You will be required to provide copies of certified documents such as a marriage license, birth certificate, adoption contract or judge signed court order to verify your dependent relationship.</p> <p>Note: Coverage will not be updated until verification is approved. The Plan has the right to determine whether or not the documentation satisfies Plan requirements. Coverage will be updated from the qualifying event date or 1st day of current plan year, whichever is later.</p>	

Who	Description	Who Determines Eligibility
	<p>For a Covered Dependent age 19 & older...</p> <ul style="list-style-type: none"> ▪ ... and a Full-time Student under the age 26 <p>You must:</p> <ul style="list-style-type: none"> ▪ update SHBP annually on student status by requesting a <i>certification letter</i> from the school's registrar and sending it attached to a <i>Dependent Student Status Information Form</i> to SHBP ▪ the certification letter must include: <ul style="list-style-type: none"> — enrollment date(s) for both current and previous quarters or semesters — number of credit hours taken each quarter or semester — enrollment status (full or part-time) for each quarter or semester — a letter of acceptance can be submitted to temporary extend coverage for students who graduate from high school in May and plan to attend college for the fall semester or students transferring between colleges. A <i>Dependent Student Status Information</i> form and certification letter must be submitted to provide coverage beyond the summer. 	

Who	Description	Who Determines Eligibility
	<p>For a Covered Dependent age 19 & older...</p> <ul style="list-style-type: none"> ▪ ... and disabled before age 26 <p>You must:</p> <ul style="list-style-type: none"> ▪ file a written request for continuation of coverage within 31 days of the 19th birthday if disabled prior to age 19 and within 31 days of the disability if disabled after age 18 but prior to age 26. ▪ when requested by the Plan you must re-certify your dependent(s). If you fail to re-certify your dependent within 31 days of the request, your dependent will no longer be eligible to be covered under the Plan until verification is received. If documentation is received after 31 days, the plan will cover the dependent retroactively to the beginning of the current plan year or date of qualifying event, whichever is later, as long as the correct tier premium is paid. <p>To enroll a disabled child as a new dependent</p> <p>You must:</p> <ul style="list-style-type: none"> • make request within 31 days of your hire date or qualifying event date • provide medical documentation that must be approved by the Plan • child must be disabled prior to age 26 • add during Open Enrollment period <p>A general note regarding documentation sent to the Plan: While the Plan requires that coverage requests are made within a specific time period, the documentation required <i>to support your request</i> may be filed later, if necessary within the 31 days following the deadline to file the coverage request.</p>	

Who	Description	Who Determines Eligibility
	<p>Qualified Medical Child Support Order (QMCSO)</p> <p>SHBP will honor a QMCSO for eligible dependents. A QMCSO creates, recognizes, or assigns the right for a dependent to receive benefits under a health plan. See <i>Glossary of Key Terms and Coverage Changes At Qualifying Events</i> for more information.</p>	
	<p>Who's Not Eligible For Dependent Coverage</p> <p>The most common examples of persons not eligible for SHBP dependent coverage include:</p> <ul style="list-style-type: none"> • Your former spouse • Your fiancé • Your parents • Married or formerly married children • Children age 19 or older who do not qualify as Full-time Students or disabled dependents • Children in military service • Grandchildren who cannot be considered eligible dependents • Stepchildren who do not live in your home at least 180 days per year <p>Anyone living in your home that is not related by marriage or birth, unless otherwise noted.</p>	

When to Enroll and When Coverage Begins

You *must* enroll to have SHBP coverage. To enroll, go to your personnel/payroll office for instructions. You will be asked to:

- Choose a coverage option
- Choose a coverage tier
- Name of eligible dependents you want to enroll and cover

Enrollment authorizes periodic payroll deductions for premiums. If you list dependent(s) you must elect a coverage tier that covers the dependent relationship to you. If you cover dependents and do not provide documentation to verify eligibility you will be charged the tier you elected. Once dependents are verified the coverage will be effective from the date of the qualifying event or the 1st day of the current plan year, whichever is later. Please refer to “Who is eligible for coverage” for more information. Once you make your coverage election, changes are not allowed outside the Open Enrollment period, unless you have a qualified change in status under Section 125 of the Internal Revenue Code, which restricts mid-year changes to coverage in the SHBP. **Special Note: If you terminate employment and are re-hired by any employer eligible for the SHBP during the same Plan year, you must enroll in the same Plan option and tier, provided you are eligible for that option and have not had a qualifying event since coverage ended.**

Important Plan Membership Terms

The Plan uses these terms to describe Plan Membership:

- Enrolled Member – You, the contract/policy holder
- Dependent(s) – your eligible dependent(s) that you choose to enroll

Where appropriate, this SPD relies on these terms throughout the document:

- Employee, retiree or member... to refer to Enrolled Member
- Dependent(s)... to refer to Dependent(s)

DCH Surcharge Policy

Spousal Surcharge:

A spousal surcharge will be added to your monthly premium if you elect to cover your spouse and your spouse is eligible for coverage through his/her employment but chose not to take it. The spousal surcharge can be removed in certain circumstances by completing the spousal surcharge affidavit and attaching the required documents. Details can be found on the Department of Community Health Web site, www.dch.georgia.gov/shbp_plans.

Tobacco Surcharge:

A tobacco surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous twelve months. The tobacco surcharge may be removed by completing the tobacco cessation requirements. Details can be found on the Department of Community Health Website, www.dch.georgia.gov/shbp_plans.

Initial Enrollment Period	<p>Eligible Persons may enroll themselves and their Dependents.</p>	<p>Enrollment must be completed within 31 days of your date of hire.</p>
<p>The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.</p>		
Open Enrollment Period	<p>Open Enrollment occurs every fall for the following plan year. Eligible Persons may enroll themselves and their Dependents.</p> <p>Any dependent(s) removed during the Open Enrollment period are not eligible for COBRA.</p>	<p>The SHBP determines the Open Enrollment Period. Coverage begins on January 1st of the following Plan year</p>
If you are:	You can enroll:	Your coverage takes effect:
<ul style="list-style-type: none"> ▪ A current employee 	<ul style="list-style-type: none"> ▪ Or make coverage changes during Open Enrollment ▪ Or make coverage changes within 31 days of a qualified event or upon loss of all eligible dependents if request is made within 31 days 	<ul style="list-style-type: none"> ▪ The upcoming January 1 ▪ First of the month following request
<ul style="list-style-type: none"> ▪ A newly hired employee 	<ul style="list-style-type: none"> ▪ Within 31 days of your hire date 	<ul style="list-style-type: none"> ▪ First of the month after a full calendar month of employment

Enrolling A Newly Eligible Dependent

If you have a new dependent due to marriage, birth, adoption, or full-time student enrollment you may enroll your dependent if you request coverage within 31 days of the qualifying event. Please contact your personnel/payroll office for instructions. **Do not wait for verification documentation to enroll dependent(s).**

The next section describes what you need to do if you wish to add a newly eligible dependent.

	To enroll a newly eligible dependent and...	You will need to:
Newly Eligible Dependent	... if your dependent is currently eligible for the tier you are enrolled in.	You must add within 31 days of the birth*, marriage, or adoption.
	If your current tier does not cover dependents	You must change tier within 31 days of qualifying event, pay appropriate premium, and add dependent
	You have a court order, requiring you to enroll dependent child(ren)	Enroll in coverage Enroll the eligible child(ren); coverage starts on first day of month following the request. You must change tier and pay appropriate premium if current tier does not include dependent(s)
<i>*To make coverage retroactive to the child's birth or placement, you must make the appropriate coverage premium payment(s) for coverage for the month of the birth or adoption contract and placement.</i>		

Identification Cards

After you enroll, you will receive an identification (ID) card for yourself and eligible dependent(s), if applicable. The ID card must be presented when care is received.

If you do not receive your ID card within two weeks of new enrollment, or by January 1st from changes made during Open Enrollment, please contact United HealthCare Insurance Company Customer Service at 877-246-4189 (Active) or 877-246-4190 (Retiree).

When Coverage Begins

For You

When your coverage starts depends on when you enroll and when you make requests that affect your coverage.

If you enroll:	Your coverage begins:
During an Open Enrollment period	On January 1 st of the new Plan year
As a new employee	On the first day of the month following one full calendar month of employment
When you are reinstated or return to work from an unpaid leave of absence that occurred during the Open Enrollment period	On the first day of the month following the return or, if a judicial reinstatement, on the day specified in the settlement agreement
When you have a qualifying event	On the first day of the month following the request

Transferring Employees

If you are transferring between participating employers:

- Contact your new employer to coordinate continuous coverage
- You must continue the same coverage, unless you had a qualifying event that allows a change in coverage

There is no coverage lapse when your employment break is less than one calendar month and your new employer deducts the premium from your first paycheck.

For Your Dependents

As a new employee, dependent coverage begins when your coverage begins. If you add dependents within 31 days of a qualifying event, coverage takes effect as described in the chart below. You must provide the following documentation before claims will be paid.

	If you add this dependent...	Coverage takes effect:
* Within 31 days prior to or after the qualifying event.	A baby Copy of certified birth certificate or a certification letter of birth required	On the first day of the month following the request; or On the day your child was born, if the proper premium is paid for the birth month; Note: Do not hold request waiting for documentation. If documentation is received after 31 days the plan will cover the dependent retroactively back to the beginning of the current plan year or date of qualifying event, whichever is later, as long as premiums are paid.

	If you add this dependent...	Coverage takes effect:
* Within 31 days prior to or after the qualifying event	An adopted child Copy of certified adoption certificate required	<i>When you already have coverage that includes children:</i> <ul style="list-style-type: none"> • On the date of legal placement and physical custody <i>When you do not have a tier that covers dependent children</i> <ul style="list-style-type: none"> • On the date of legal placement and physical custody, if the correct tier premium is paid from the time of placement and custody • Request a tier coverage change
* Within 31 days prior to or after the qualifying event	A new spouse Copy of certified marriage certificate required Due to new Centers for Medicare & Medicaid Services (CMS) regulations, the spouse's social security number is required.	<ul style="list-style-type: none"> • Change to a coverage tier to include spouse <i>When coverage begins:</i> <ul style="list-style-type: none"> • On the first day of the month following the request

	If you add this dependent... Coverage takes effect:	
* Within 31 days prior to or after the qualifying event	Stepchild(ren)	
	Copy of certified birth certificate showing your spouse is the natural parent; and copy of certified marriage license showing the natural parent is your spouse; and notarized statement that dependent lives in your home at least 180 days per year	On the first day of the month following the qualifying event or your change to the appropriate coverage tier

*Note: When you add a dependent the Plan will request dependent verification documentation. You must submit the documentation requested by the Plan in order to cover the dependent. **If documentation is received after 31 days the plan will cover the dependent retroactively back to the beginning of the current plan year or date of qualifying event, whichever is later, as long as the correct tier premium is paid.**

Qualifying Events that Allow Coverage Changes for Active Members

If you are an actively employed Member and have one of the following qualifying events during the year, you may be able to make a coverage change that is consistent with the qualifying event. If you are a retiree, refer to the retiree section for permitted coverage changes. The following chart shows qualifying events and the corresponding changes that active Members can make:

If you have one of these qualifying events:	Within 31 days of qualifying event, you may:
Marriage Certified copy of marriage certificate required Due to new Centers for Medicare & Medicaid Services (CMS) regulations, the spouse's social security number is required.	<ul style="list-style-type: none">• Change coverage tier to include spouse• Discontinue coverage; letter from other plan documenting you and your covered dependents are enrolled in spouse's plan
Birth, adoption or legal guardianship <ol style="list-style-type: none">1) Birth: Copy of certified birth certificate or letter of certification of birth.2) Adoption: Adoption certificate or court order placing child in home3) Legal guardianship: Copy of court's legal documentation showing your financial responsibility for the dependent; and copy of certified birth certificate; and for legal guardianship a notarized statement that dependent lives with you in your home on a permanent basis	<ul style="list-style-type: none">• Enroll in coverage• Change coverage tier• Enroll eligible dependents• Change to any available option

	If you have one of these qualifying events:	Within 31 days of qualifying event, you may:
	<p data-bbox="758 277 1320 342">Copy of divorce decree and loss of coverage documentation required</p> <p data-bbox="758 431 1045 464">Copy of divorce decree</p>	<ul data-bbox="1356 277 1856 667" style="list-style-type: none"> <li data-bbox="1356 277 1856 342">• Enroll in coverage, if losing through spouse coverage <li data-bbox="1356 440 1787 472">• Remove spouse from coverage <li data-bbox="1356 505 1856 537">• Remove step children from coverage <li data-bbox="1356 570 1667 602">• Change coverage tier <li data-bbox="1356 634 1730 667">• Enroll eligible dependents
	<p data-bbox="758 691 1320 756">You or your spouse loses coverage through other employment</p> <p data-bbox="758 789 1320 854">Letter from other employer documenting loss of coverage and reason for loss is required</p>	<ul data-bbox="1356 691 1745 854" style="list-style-type: none"> <li data-bbox="1356 691 1745 724">• Enroll eligible dependent(s) <li data-bbox="1356 756 1646 789">• Enroll In Coverage <li data-bbox="1356 821 1667 854">• Change coverage tier
	<p data-bbox="758 886 1320 1024">You, your spouse, or enrolled dependent loses or discontinues health benefit coverage through other employment, Medicaid* or Medicare</p> <p data-bbox="758 1057 1320 1122">“Does not include spouse’s Open Enrollment election” if same plan year</p> <p data-bbox="758 1154 1320 1252">Letter from other employer, Medicaid, or Medicare documenting date and reason for loss or discontinuation required</p>	<ul data-bbox="1356 886 1745 1049" style="list-style-type: none"> <li data-bbox="1356 886 1745 919">• Enroll eligible dependent(s) <li data-bbox="1356 951 1646 984">• Enroll In Coverage <li data-bbox="1356 1016 1667 1049">• Change coverage tier <p data-bbox="1356 1138 1913 1235">* Note: Effective April 1, 2009 for Medicaid only the 31 days changes to 60 days for actions above</p>

	If you have one of these qualifying events:	Within 31 days of qualifying event, you may:
	<p>Your spouse or your only enrolled dependent's employment status changes, resulting in a gain of coverage under a qualified plan</p> <p>"Does not include spouse's Open Enrollment election" if same plan year</p> <p>Letter from other employer documenting coverage enrollment required and everyone covered under the SHBP must be enrolled in the plan</p>	<ul style="list-style-type: none"> • Change coverage tier • Discontinue coverage
	<p>Your former spouse loses coverage or plan is cancelled, resulting in loss of your dependent child(ren) coverage</p> <p>Letter from other plan documenting name, date, reason, and when coverage was lost.</p>	<ul style="list-style-type: none"> • Enroll eligible dependent(s) • Enroll In Coverage • Change coverage tier
	<p>You or spouse acquire new coverage under spouse's employer's plan</p> <p>Letter from other plan documenting your effective date of coverage and names of covered dependents</p>	<ul style="list-style-type: none"> • Change to employee only coverage • Discontinue coverage – you must document your spouse's plan covers all dependents

	If you have one of these qualifying events:	Within 31 days of qualifying event, you may:
	<p>Your spouse makes an Open Enrollment change under spouse's employer's plan, creating an overlap or break in coverage because spouse's coverage has a different plan year</p> <p>Letter from other plan documenting overlap or break in coverage is required</p>	<ul style="list-style-type: none"> • Enroll in coverage • Enroll eligible dependents(s) • Change coverage tier • Discontinue coverage you must document your spouse's plan covers all dependents
	<p>You or your spouse is activated into military services</p> <p>Copy of orders required</p>	<ul style="list-style-type: none"> • Enroll in coverage • Change coverage tier • Discontinue coverage
	<p>You retire and immediately qualify for a retirement annuity</p> <p>You must complete and submit Plan enrollment form no later than 60 days after leaving active employment</p> <p>Note: If your retirement system is ERS, TRS or PSERS you will automatically be enrolled in same option and tier as a retiree. You will receive a letter from SHBP advising you that the change was made and allowing you to make changes to coverage.</p>	<ul style="list-style-type: none"> • Change coverage tier to single • Change Option <p>Note: If you have employee + spouse, employee + child(ren), employee + child(ren) + spouse, you will be changed to family tier.</p>

If you have one of these qualifying events:	Within 31 days of qualifying event, you may:
You, your spouse, or all enrolled dependents become eligible for Medicare or Medicaid	As a Active Employee <ul style="list-style-type: none">• If no eligible dependents(s) can discontinue coverage
Required to submit proof of enrollment in Part A, B, and D to reduce premiums	As a Retiree <ul style="list-style-type: none">• Discontinue your dependent(s) coverage – if you are retired and you discontinue your SHBP coverage when you enroll for Medicare, you won’t be able to enroll again for SHBP coverage• Retirees may change to any available option upon becoming eligible for Medicare coverage.
Loss of all covered dependents may be through divorce, death, legal separation, an only covered dependents exceeding the maximum age of eligibility, an only covered dependent no longer meeting full-time student requirements, marriage of an only covered dependent child, or a Qualified Medical Child Support Order (QMCSO) requiring a former spouse to provide health coverage for all covered natural children. You must notify SHBP within 31 days of qualifying event to change your coverage tier. You next opportunity to change coverage tier would be during Open Enrollment.	

Qualified Medical Child Support Orders

If a QMCSO requires:	You can:
You to provide coverage for your natural child(ren).	<ul style="list-style-type: none">• Enroll or change coverage tier – there is no time limit for this change; documentation of the court order and the other coverage is required
Your former spouse to provide coverage for each of your enrolled natural child(ren)	<ul style="list-style-type: none">• Change coverage tier; documentation of the court order and the coverage is required
Spouse to provide coverage for their natural children	<ul style="list-style-type: none">• Enroll or change coverage tier – is no time limit for this change; documentation of the court order requiring coverage• Change coverage tier; documentation of the court order and the coverage is required• Child must meet all step-child requirements including annual 180 day residency with member to qualify for coverage.

Generally, a change in coverage takes effect the first of the month following receipt of the change request.

Important Note on Coverage Changes:

If your current Plan option is not offered in the upcoming Plan year and you do not elect a different option available to you during Open Enrollment or the Retiree Option Change Period, your coverage will be transferred automatically to an option selected by SHBP with any applicable surcharges, effective January 1 of the subsequent Plan year.

General Information about When Coverage Ends

We may discontinue this benefit Plan and/or all similar benefit plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred after your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Member's coverage ends.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

For You

Your coverage will end if:

- You no longer qualify under any category listed under the eligibility rules and your payroll deductions for coverage have ceased.
- You do not make direct pay premium payments on time
- You resign or otherwise end your employment
- You are laid off because of a formal plan to reduce staff
- Your hours are reduced so that you are no longer benefits eligible
- You do not return to active work after an approved unpaid leave of absence
- You are terminated by your employer
- Member contributions not remitted to the Plan by the due date may result in suspension/and or termination of coverage.

Coverage for Member ends at the end of the month following the month in which the last premium is deducted from your earned paycheck or at the end of paid coverage. Premiums will not be deducted from final leave pay.

Note: If an Employing Entity fails to remit Premiums or documentation or fails to reconcile bills in the manner required by the Plan, the Plan may suspend benefit payments for Enrolled Members of the Employing Entity. Suspended coverage is not a COBRA event; however, the member may continue coverage if the member is eligible for continuation of coverage rights as defined in Section 9: Continuation of Coverage under COBRA and pays both the employer and employee share of the cost.

When Coverage May Be Continued

SHBP allows individuals to continue their SHBP coverage in certain situations when it would have otherwise ended.

<i>If you have this situation:</i>	<i>You will be affected in this way:</i>
Leave your job with less than 8 years of services	Continue coverage for up to 18 months under COBRA provisions
Leave your job and: Have at least eight years of service but less than 10	Continue coverage by: <ul style="list-style-type: none">• Submitting form(s) within 60 days of when coverage would end• Pay full cost of coverage• Provide statement from your employer verifying your service
Leave your job and: <ul style="list-style-type: none">▪ Have at least 10 years of service but before minimum age to qualify for an immediate retirement annuity▪ You leave money in retirement system	Continue coverage by: <ul style="list-style-type: none">• Submitting appropriate form(s) within 60 days of when coverage would end• Pay the full cost of coverage until your annuity begins• Pay lower member premium once annuity begins

The chart above applies for most SHBP members; certain parts of the Georgia code may stipulate other conditions for SHBP continuation.

For Your Dependents

Coverage for your dependents will end at the same time you lose coverage because you are no longer eligible. Here are other situations that can affect coverage for you and your dependents.

Situation	Effect on coverage
If enrolled dependent is a stepchild under age 19 and does not meet the 180-day residency requirement	Coverage ends at the end of the month when the dependent no longer meets the 180-day residency requirement
<p>If enrolled dependent is a Full-time Student at an accredited college, university or other institution</p> <p>NOTE: For Retirees members: Failure to submit full-time student verification before coverage ends at age 19 and each subsequent year will result in loss of eligibility for dependent, unless they re-enroll within 31 days of a qualifying event.</p> <p>For Active member: Verification documentation must be submitted timely for a student to be covered under the Plan. Once verification documentation is received, coverage will be retroactive to the qualifying event date or 1st day of the coverage plan year, whichever is later</p>	<p>Coverage ends on the last day of the month in which the earliest of these qualifying events occurs:</p> <ul style="list-style-type: none">• Graduation or completion of requirements if graduation is delayed• Full-time attendance ends – unless child has attended previous two consecutive semesters and plans to return after a one semester break• Dependent reaches age 26• Dependent marries• Dependent becomes employed in a benefits eligible position

	Situation	Effect on coverage
	If you divorce , your spouse loses coverage as your dependent*	Coverage ends at the end of the month in which the divorce becomes final
	If you or your spouse or eligible dependent(s) loses other group health insurance coverage because of change in employment	Before you lose coverage or within 31 days after losing coverage, file request for SHBP coverage, which will start on the first day of the month following the request
	If you declined coverage for yourself or your dependents because of other group health insurance coverage, and you later lose that coverage	You may enroll yourself and dependents if you request this coverage within 31 days of the qualifying event. Coverage will be effective on the first day of the month following the request.

* If you receive a court order to provide health coverage for a divorced spouse, you may temporarily continue Plan coverage for the divorced spouse by electing COBRA continuation coverage, which is limited to 36 months of coverage. You must request a COBRA information packet from the SHBP within 60 days of the qualifying event.

Coverage for a Disabled Child

You may apply during the Open Enrollment period, to enroll over age disabled child not covered under SHBP prior to age 19, but who was disabled prior to age 26

- Is not able to be self supporting because of mental or physical disability.
- Depends mainly on the Member for support.

Coverage will continue as long as the Enrolled Dependent meets the disabled dependents requirements or unless coverage is otherwise terminated in accordance with the terms of the Plan.

We will ask you to furnish SHBP with proof of the child's disability and dependency within 31 days of the date coverage would otherwise have ended because the child reached age 19 or upon enrollment in the plan

SHBP may continue to ask you for proof that the child continues to meet these conditions of disability and dependency.

The dependent's coverage will remain inactive until the appropriate documentation has been received and verified by SHBP.

How to Request a Change

During Open Enrollment and the Retiree Option Change Period, Members can go online to make coverage changes for the upcoming Plan year. See the current *Health Plan Decision Guides* for Web addresses and instructions. If you do not have Internet access or if your request is in the middle of a Plan year, then:

- **Notify your personnel/payroll office.** If you are retired, contact the SHBP eligibility unit directly or your former employer's personnel office.
- **Return completed forms.** You must make your change by the appropriate deadline.

If you miss the deadline, you won't be able to make your change until the next Open Enrollment or qualifying event period. Changes permitted for retirees are limited, please refer to the retiree section for more details.

Section 5: Provisions for Eligible Retirees & Considerations for Members Near Retirement

Plan Membership

This section includes Plan Membership and co-ordination of benefits information for eligible retirees as well as important points to consider if you are near retirement. Currently, SHBP will pay primary benefits for non-enrolled Medicare eligible retirees as well as retirees who are not entitled to Medicare because they did not participate in Social Security or pay Medicare taxes.

Effective July 1, 2009, there will be an increase in premiums for retirees who are eligible for Medicare because of disability or age 65 or older who are not enrolled in Medicare Part B. Individuals who have lived at least 5 years in the United States may purchase Medicare Part B coverage, even if you did not contribute to Social Security or work the number of required quarters.

SHBP will continue to pay primary benefits for Medicare non-enrolled retirees but the premiums will be much higher.

Eligibility

You may be able to continue Plan coverage if you are enrolled in the Plan when you retire and are immediately eligible to draw a retirement annuity from any of these systems:

- Employees' Retirement System (ERS)
- Teachers Retirement System (TRS)
- Public School Employees Retirement System (PSERS)
- Local School System Teachers Retirement Systems
- Fulton County Retirement System (eligible Members)
- Legislative Retirement System
- Superior Court Judges or District Attorney's Retirement System

Important Note: Individuals who have withdrawn all money from their respective retirement system will not be able to continue health coverage as a retiree. Eligibility for temporary extended coverage under COBRA provisions would apply.

Applying for Coverage Continuation

If you are an eligible retiree, you must apply for continued coverage for yourself and Covered Dependents within 60 days of the date your active coverage ends. Application can be made on a *Retirement/Surviving Spouse Form*, available through your personnel/payroll office or by contacting the Plan's Eligibility Section. Members of ERS, TRS, and PSERS will be automatically enrolled in the same option they had as an active employee. These members will receive a letter from SHBP advising them the change was made and allowing them to make changes to their option within 31 days of the date of the letter. **Failure to apply timely or make the appropriate premium payments terminates your eligibility for retiree coverage.**

When Coverage Begins

If you are eligible for a monthly annuity at the time you retire, your coverage starts immediately at retirement, provided that you make proper premium payments or have them deducted from your annuity check. Coverage for your dependents (if you elect to continue dependent coverage) starts on the same day that your retiree coverage begins. A change from single to family coverage as a retiree is allowed only when you have a qualifying event.

When Coverage Ends:

For You

Coverage will end when you discontinue coverage or fail to pay premiums on time.

For Your Dependents

Coverage for your dependents will end when:

- They are no longer eligible
- Fail to document eligibility
- You change from family to single coverage
- You do not pay premiums on time
- Your coverage as a Member ends.

Keep in mind that if dependents are dropped from your coverage, you will *not* be able to enroll them again – unless you have a qualifying event.

Continuing Dependent Coverage at Your Death

In the event of your death, your covered surviving spouse or eligible dependents should contact the applicable retirement system (ERS, TRS, PSERS, etc.) and the Plan as soon as possible. To continue coverage, surviving spouses or eligible children must complete a Retirement/Surviving Spouse Form and send it to the Plan within 31 days of your death.

Plan provisions vary for survivors:

Surviving spouse receives annuity

- Plan coverage may continue after your death
- Premiums will be deducted from annuity
- Spouse sends payments directly to Plan if annuity is not large enough to cover premium
- New dependents or spouses *cannot* be added to survivor's coverage
- Surviving spouse who become eligible for SHBP coverage as an active employee must discontinue the surviving spouse coverage and enroll as an active employee.

- When you return to a surviving spouse status, surviving spouse coverage may be reinstated after notifying the Plan within 31 days. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a surviving spouse.

Surviving spouse does not receive annuity

- Plan coverage may continue after your death if spouse was married to you at least one year before death
- Spouse sends payments directly to the Plan
- Coverage ends if surviving spouse remarries

Surviving child does not receive annuity and there is no surviving spouse

- Plan coverage may continue under COBRA provisions

Making Changes to Your Retiree Coverage

You can make changes to your coverage tier only at these times:

- Within 31 days of a qualifying event
- During the annual Retiree Option Change Period
 - You may change your Plan option only
 - Adding dependents is not permitted unless you have a qualifying event as described in the section below.

Note: Upon retirement, your coverage will be changed to single or family, based on your covered dependents.

If you and your dependents enroll in the UHC Medicare Advantage Private Fee for Services with Prescription Drugs (MA PFFS-PD) option, any dependents not eligible for MA PFFS-PD option will be enrolled in the UHC HRA option.

Qualifying Events

If you have this qualifying event...	You may...
<ul style="list-style-type: none"> • Within 31 days of eligibility for retiree coverage • Annuity no longer covers premium amount • Become eligible for Medicare 	Change to an available option
<ul style="list-style-type: none"> • Acquire dependent because of marriage, birth, adoption or Qualified Medical Child Support Order (QMCSO) • Within 31 days of non-voluntary loss of a dependent's health benefit coverage through spouse's or Medicaid, Medicare, group coverage through employment, retirement or COBRA coverage 	Add your eligible dependent(s) Proper documentation is required <i>*Surviving spouses and dependents cannot change from single to family coverage</i>
Note: Discontinuation because of an increase in premium is not a qualifying event.	
<ul style="list-style-type: none"> • Spouse or enrolled dependent's employment status changes, affecting coverage eligibility under a qualified health plan 	Change coverage tier within 31 days of the qualifying event; proper documentation is required

	If you have this qualifying event.....	You may.....
	<p>You and spouse are both retirees who both have sufficient retirement benefits from a covered retirement system to have Plan premiums deducted.</p> <p>New dependents or spouses <i>cannot</i> be added to survivor's coverage.</p>	<p>Change at any time from family coverage to each having single coverage; a request to change from family to single for you and the request for single coverage for your spouse must be filed at the same time.</p>
<p>Note: It is the loss of eligibility for their current coverage not retirement, discontinuation or reduction of benefits that is the qualifying event.</p>		

You must request a coverage change within 31 days of the qualifying event by:

- Contacting the Plan directly
- Returning the necessary form(s) with any requested documentation to the Plan by the deadline. * Fill out the form(s) completely. If adding a spouse due to marriage, new Centers for Medicare & Medicaid Services (CMS) regulations require SHBP capture the spouse's social security number.

If you miss the deadline, you will not have another chance to make the desired change. If the deadline is met, your change will take effect on the first day of the month following the receipt of your request, unless indicated above.

*** Do not hold form requesting change even if you are waiting on documentation. Request must be made within 31 days of qualifying event.**

Changes Permitted Without A Qualifying Event

Retirees may change from family to single coverage, or discontinue coverage at anytime by submitting the appropriate Plan form. However, if you change from family to single coverage, you cannot increase your coverage later without a qualifying event. **If you discontinued coverage, you may not enroll later unless you return to work in a State of Georgia benefit eligible position.**

Important Note On Coverage Changes: If your current Plan option is not offered in the upcoming Plan year and you do not elect a different option available to you during the Retiree Option Change Period, your coverage will be transferred automatically to an option selected by SHBP effective January 1 of the subsequent Plan year.

Retiree Option Change Period

During the 30-day Retiree Option Change Period, generally from mid-October to mid-November each Plan year, you can make these changes to your coverage:

- Select a new coverage option
- Change from family to single coverage
- Discontinue coverage (Note that re-enrollments are not allowed.)

Changes will take effect the following January 1.

Before the Retiree Option Change Period begins, the Plan will send you a retiree information packet. The packet will include:

- Information on the Plan options
- Steps for notifying the Plan about coverage selections for the new Plan year
- Forms you may need to complete
- Informational resources.

To ensure that you receive the information packet, make sure the Plan always has your most up to date mailing address.

If You Return to Active Service

If you choose to return to active service with an employing entity under the Plan, whether immediately after you retire or at a later date, your retirement annuity may be suspended or continued. Health Plan coverage, however, must be purchased as an active employee and through payroll deduction by your employer. You will need to complete enrollment paperwork with your employer and the appropriate form to have the deduction stopped with the retirement system.

When you return to retired status, retiree coverage may be reinstated after notifying the Plan within 31 days. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a retiree.

If you retired before the initial legislative funding for a particular employee group, you will not be entitled to retiree Plan coverage unless the final service period qualifies you for a retirement benefit from a state supported retirement system.

Special Note: Re-enrollment into retiree coverage is not automatic. You must request coverage within 31 days of loss of active coverage or you will lose eligibility for retiree coverage.

Impact of Medicare on Benefits/Premiums

Coordination of Benefits With Medicare

Medicare is the country's health insurance program for people age 65 or older who qualify based on Medicare eligibility rules. Medicare also covers certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure.

To prevent duplicate benefit payment, the Plan coordinates benefits with Medicare and any other plan that may cover you and your dependents. The first step in coordination is the determination of which plan is primary or which plan pays benefits first and which plan is secondary. Under Georgia law, the SHBP is required to subordinate health benefits to Medicare benefits.

The chart below provides important details related to primary and secondary coverage based on your Medicare status:

If you are retired and ...	The Plan will pay...
...age 65, Medicare eligible and enrolled in Part A, Part B, and Part D; consider enrolling prior to the month in which you turn 65 to maximize coverage and pay the lowest premium	Secondary benefits starting on the first day of the month in which you turn 65
...age 65, Medicare eligible and do <i>not</i> enroll in Part A, Part B and Part D	Primary benefits; however, Plan premium will increase
...age 65 or older and not entitled to Medicare	Primary benefits; however, Plan premium will increase

State Health Benefit Plan (SHBP) Medicare Policy

- Georgia law requires that SHBP pay benefits after Medicare has paid.
- SHBP will calculate premiums and claims payments based upon Medicare enrollment for retirees over 65 or those eligible for Medicare due to a disability.
- Premiums will be based on the Parts of Medicare (A, B and D) that you have. There will be no adjustments in premiums because you have other coverage such as TRICARE, VA or other group coverage since SHBP may have potential primary liability.
- SHBP will coordinate benefits for members who are enrolled in Medicare A, B or D.
- SHBP will pay primary benefits on members not eligible or not enrolled in Medicare, but you will pay a higher premium.
- If you enroll in Medicare (A, B or D), please send a copy of your Medicare cards by the first month in which you are eligible for Medicare. Premiums cannot be reduced until copies of your Medicare cards are received and the change in premium is processed by the retirement system. Delay in submission of Medicare information does not qualify for a refund of the difference in premiums.

Medicare information is available at:

- www.cms.hhs.gov/medicarereform
- www.medicare.gov
- www.ssa.gov
- 1-800-669-8387 (Georgia Cares)
- 1-800-633-4227 (Medicare)

Section 6: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Contracted provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a non-Contracted provider, you are responsible for filing a claim and payment.

If You Receive Covered Health Services from a Contracted provider

We pay Contracted providers directly for your Covered Health Services. If a Contracted provider bills you for any Covered Health Service, contact United HealthCare. However, you are responsible for meeting the Annual Deductible and for paying Copayment/Coinsurance to a Contracted provider at the time of service, or when you receive a bill from the provider.

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Contracted provider:

You must submit a request for payment of Benefits within 24 months following the month of service. If you do not submit this information within the specified time limit the claim will not be paid. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the month of service is the date your Inpatient Stay ends.

Claim forms may be obtained from myuhc.com or by contacting customer service.

Medicare Part D Information

If you are not enrolled in Medicare Part D, you may enroll during the Medicare annual open enrollment, November 15 - December 31. This open enrollment is held by the Centers for Medicare and Medicaid (CMS) and not by SHBP. In many cases, you do not need the enhanced prescription drug plan. Your individual pharmacy needs will indicate the level of coverage that is best for you.

Coordination of Pharmacy Benefits between your Prescription Drug Plan (PDP) and SHBP

- Each time you go to the pharmacy, present both your Medicare Part D and SHBP identification cards.
- When Medicare coordination of benefits occurs, you should not be responsible for more than your SHBP copayment for eligible charges.
- When you reach the PDP coverage gap, you should still present both identification cards and you will pay your SHBP copayment.

Required Information

When you request payment of Benefits from us, you must provide all of the following information:

- A. Member's name and address.
- B. The patient's name, age and relationship to the Member.
- C. The member number stated on your ID card.
- D. An itemized bill from your provider that includes the following:
 - Patient diagnosis
 - Date of service
 - Procedure code(s) and description of service(s) rendered
 - Provider of service (Name, Address and Tax Identification Number)
- E. The date the Injury or Sickness began.
- F. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

Through United HealthCare, we will make a benefit determination as set forth below.

You may assign your Benefits under the Plan to a non-Contracted provider.

United HealthCare will notify you if additional information is needed to process the claim. United HealthCare may request a one time extension not longer than 15 days and will pend your claim until all information is received. Once you are notified of the extension or missing information, you then have at least 45 days to provide this information.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from United HealthCare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. United HealthCare will notify you within this 30-day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, United HealthCare will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving the requested medical care. If your claim is a pre-service claim, and is submitted properly with all needed information, you will receive written notice of the pre-service claim decision from United HealthCare within 15 days of receipt of the claim. If you filed a pre-service claim improperly, United HealthCare will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, United HealthCare will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, United HealthCare will notify you of the pre-determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after United HealthCare receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent claim improperly, United HealthCare will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, United HealthCare will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- United HealthCare's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. United HealthCare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the timeframes described above. If an on going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Section 7: Questions, Complaints and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You have a complaint.
- How to handle an appeal that requires immediate action.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

United HealthCare Insurance Company
PO Box 30994
Salt Lake City, Utah 84130-0994

If a request for Plan benefits is denied, either totally or partially, you or your dependents will receive a notice of denial either electronically or in writing – or, in case of Urgent Care, notice is verbal and then followed by an electronic or written notification.

To resolve a question or appeal, just follow these steps:

What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in (Section 6: How to File a Claim) you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of United HealthCare.

If you are appealing an urgent care claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact United HealthCare in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).

- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to United HealthCare within 180 days after you receive the claim denial.

Appeal Process – How to Appeal an Eligibility Decision

SHBP will handle all eligibility appeals. Please forward all request for eligibility appeals along with a completed appeal form to: State Health Benefit Plan, Membership Correspondence Unit, P. O. Box 1990, Atlanta, GA 30301. The appeal forms are available through your Personnel/ Payroll office, website address www.dch.georgia.gov/shbp_plans or directly from the SHBP. All member correspondence sent to the Plan should include the Enrolled Member's Social Security Number (SSN) to prevent a delay in processing your request.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of pre-service claims, as defined in (Section 6: How to File a Claim), the first level appeal will be conducted and you will be notified by United HealthCare of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by United HealthCare of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims as defined in (Section 6: How to File a Claim), the first level appeal will be conducted and you will be notified by United HealthCare of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by United HealthCare of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of United HealthCare, you have the right to request a second level appeal from United HealthCare. Your second level appeal request must be submitted to United HealthCare in writing within 60 days from receipt of the first level appeal decision.

For pre-service and post-service claim appeals, SHBP have delegated to United HealthCare the exclusive right to interpret and administer the provisions of the Plan. United HealthCare's decisions are conclusive and binding.

Please note that United HealthCare's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call United HealthCare as soon as possible. United HealthCare will provide you with a written or electronic determination within 72 hours following receipt by United HealthCare of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to United HealthCare the exclusive right to interpret and administer the provisions of the Plan. United HealthCare's decisions are conclusive and binding.

Voluntary External Review Program

If a final determination to deny Benefits is made, you may choose to participate in our voluntary external review program, at your cost. The cost can range from \$500 - \$2,000. This program only applies if the decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental, Investigational or Unproven Services.

NOTE: The external review program is not available if the coverage determinations are based on explicit Benefit exclusions or defined Benefit limits. Contact United HealthCare at the telephone number shown on your ID card for more information on the voluntary external review program.

Section 8: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Filing a Claim When Coordination of Benefits (COB) applies

You and your Covered dependents may have medical coverage under more than one plan. In this case, the Plans coordination of benefits (COB) provisions apply.

When the SHBP is secondary, benefits are coordinated utilizing the non-duplication rule. Non-duplication maintains the member's same benefit level, regardless of the existence of two carriers. The Plan pays only the difference between the plan's normal benefit and any amount payable by the primary plan. The member is responsible for any remaining balance.

Non-Covered Services or items, penalties, and amounts balance billed are not part of the Allowed Amount and are the Member's responsibility.

- COB applies to group health coverage, including:
 - Government programs such as Medicare or state contracts (dual SHBP coverage)
 - Your spouse's insurance at his or her work
 - COBRA coverage
- COB does not apply to an individual policy – one for which you pay the total premium directly to the insurer.

If the 24-month timely filing limit is approaching and you have not received an explanation of benefits (EOB) from the primary plan, submit your claim(s) to the Plan without the EOB prior to the deadline. When you receive the EOB, send it to the Plan for processing, even if the deadline has passed.

For COB information that applies when you or a Covered Dependent is injured in an accident caused by another party, see *Subrogation*.

How COB Works

- When you or your dependents are covered by two group health plans, **determine which plan is the primary and which is secondary.** The primary plan is obligated to pay a claim first, which generally means that it will pay most of the expenses.
- **Submit claims to the primary plan first.** You will receive a benefit payment from that plan along with an explanation of benefits (EOB).

- **Make a copy of the EOB you received from the primary plan, attach it to a claim form and mail both to the secondary plan.** The SHBP won't pay a secondary benefit until you submit the primary plan's EOB. Indicate the name and policy number of the person who has the other coverage and that plan's group number.

If your other group coverage ends, you must report the cancellation date to Member Services in writing and include supporting documentation from the primary plan. You can get the information from your employer or from the other insurance company.

How to Tell Which Plan is Primary

Generally, a plan is primary when:

- The patient is the Member or employee
- The plan does not have coordination of benefits
- The plan is a Workman's Compensation Plan or an automobile insurance medical benefit
- The other plan is Medicare and the patient is covered under the group plan of an active employee. Those under the age 65 may qualify for Medicare because of a covered disability or end-stage renal disease. Your Plan coverage will be primary during the first part of your Medicare Member, and then Medicare will become primary. Medicare determines the length of time Plan coverage is primary.
- Note for Retirees with primary coverage through Medicare: Network PPO providers may collect the office visits Copayment/Coinsurance at the time of service. However, to avoid the possibility of an overpayment from Medicare and United HealthCare, some providers may decide not to collect the office visit Copayment/Coinsurance.

In other situations, determining which plan is primary is more complicated:

- **If the patient is a dependent child with married parents,** the plan that covers the parent whose birthday comes first in the Calendar year is primary, unless the parents are divorced. If both parents were born on the same date, the plan that has covered the parent for the longest time pays first.
- **When a plan uses the gender rule to determine the primary plan, the father's plan is primary.** If the other plan follows the gender rule, the SHBP will allow the father's plan to be primary.
- **When the patient is a dependent child whose parents are divorced,** the plan of the parent with custody pays first, except where a court decrees otherwise.
- **If the parent with legal custody has remarried:**
 - The plan of the parent with legal custody pays first.
 - The plan of the spouse of the parent with custody pays second.
 - The plan of the parent who does not have custody pays last.

If custody is joint, the plan that covers the parent whose birthday comes first in the Calendar Year is primary.

- **When two plans cover the Member as an active employee,** the plan that has covered the employee the longest pays first.
- **For active employees versus inactive employees,** a plan that covers a person:
 - As an active employee is primary over a plan that covers a person who is retired, laid off or covered under COBRA.
 - As an inactive employee is primary over a plan that covers the inactive employee as the spouse of an active employee.
 - As a dependent of an active employee is primary over Medicare coverage for a retiree.

If none of the rules described in this section apply, the plan that has covered the person the longest is primary.

If You Have Dual Plan Coverage

Coordination of benefits when both you and your spouse have Plan coverage as Member (i.e., when you have dual coverage) works like this:

- If one of you has family coverage and the other has single coverage, only the spouse with the single coverage has dual coverage.
- When both spouses have dual coverage, the coverage of the spouse who is the patient is primary.
- If the patient is a dependent, then the plan that covers the parent whose birthday comes first in the Calendar year is primary.

When you have dual coverage, you cannot transfer Deductibles between Plan contracts.

Other Forms of Duplicated Benefits

- The Plan does not duplicate payments that you may receive under third-party medical payment contracts or because of any lawsuit, including malpractice litigation.
- If you receive medical payments from underwriters of a homeowner's policy, an automobile insurance policy or any other payment plan, the Plan will consider only those charges over the amounts paid by the third party(ies).
- The Plan has the right to delay your payments until it determines whether or not other parties are liable for paying your medical expenses. However, when the employee or Covered Dependent must sue to determine the parties' obligations, the Plan will not delay payment provided that you or the payee agrees to reimburse the Plan for duplicated medical payments.

Section 9: Continuation of Coverage under COBRA

This section provides you with information about all of the following:

- Continuation of coverage under federal law (COBRA).

- Family medical reasons as provided under the Family and Medical Leave Act (FMLA) – more details below
- Military duty (emergency and voluntary) – more details below
- Suspension of employment

You will have to meet certain requirements for each leave type and your personnel/payroll office can provide you with the necessary information, including premium rates and a *Request to Continue Health Benefits During Leave of Absence Without Pay* form. Also, most leave types require supporting documentation.

You can apply for continued coverage within 31 days after starting an unpaid leave.

When Coverage may be Continued

Certain situations allow you to continue your SHBP coverage.

Unpaid Leaves of Absence

If you are an active employee on an approved unpaid leave, you may be able to continue your current coverage for up to 12 calendar months – or up to 18 calendar months for military leave.

Unpaid leave is available for:

- Disability/illness – more details below
- Educational instruction
- Employee's convenience
- Employer's convenience

Continuing Coverage During Approved Disability Leave

In case you become disabled while an active employee, the Plan has provisions that may allow you to continue coverage, which are described in the table below:

Because of a disability, you have this situation:	You will be affected in this way:
<ul style="list-style-type: none">You are Totally Disabled and are on an approved disability leave <p style="text-align: center;">OR</p> <ul style="list-style-type: none">You return to work on a part-time basis before the end of your approved disability leave and before returning to full-time work	<ul style="list-style-type: none">You will be eligible to continue health benefits for up to 12 monthsYou must pay premiums directly to SHBPCoverage is limited to whichever is less:<ul style="list-style-type: none">The disability period that your Physician certifies you must provide additional documentation of your disability period12 consecutive months if the disability continues

If you are a disabled retired Member, see Provisions for the Eligible Retirees for more information on how your coverage may be affected.

Continuing Coverage Under Family and Medical Leave Act (FMLA)

You may continue medical coverage for yourself and your dependents for up to 12 weeks for specific medical and/or family medical reasons. Forms for continuing your coverage are available from your personnel/payroll office.

During FMLA leave without pay, the SHBP will bill you directly for coverage premiums. How FMLA affects your coverage depends on the circumstances involving your leave.

If you have this situation:	You will be affected this way:
<ul style="list-style-type: none">Choose not to continue coverage while on leave	<ul style="list-style-type: none">Claims will not be paid by SHBP for the period after coverage terminates and while you remain on leave. You are responsible for paying Providers.You must resume coverage when you return to work.
<ul style="list-style-type: none">Open Enrollment period occurs while on leave	<ul style="list-style-type: none">If you continue coverage while on leave, you may change coverage as permitted during Open EnrollmentIf you do not continue coverage while on leave, contact your employer for Open Enrollment information
<ul style="list-style-type: none">Do not return to work after your leave ends and you have paid your premiums directly to the Plan during your leave	<ul style="list-style-type: none">You may be eligible to continue your medical coverage through COBRA

Continuing Coverage During Military Leave

You and your dependents have the right to continue your coverage for up to 18 months with premium payments sent directly to the SHBP.

- If you are an activated military reservist called on an emergency basis, you will pay your employee share of the premium.
- For other military leaves, you will be required to pay the full premium. Also, you will be charged a monthly processing fee.

You may elect to discontinue coverage while on leave. The SHBP will reinstate your coverage when you return from military service. However, for the time period allowed by the Veteran's Administration, the Plan does not cover care for a Member's illness or injury that the Secretary of Veterans' Affairs determines was acquired or aggravated during the military leave.

If You Leave Your Job

This chart shows how your coverage would be affected if you were to leave your job:

If you have this situation:	You will be affected in this way:
<ul style="list-style-type: none">• Leave your job with less than eight years of service• Take another job that does not qualify you for coverage• Move to part-time status• Are laid off	<ul style="list-style-type: none">• You can continue coverage for up to 18 months under COBRA provisions
Leave your job and: <ul style="list-style-type: none">• Have at least eight years of service, but less than 10 years	<p>You can continue coverage by:</p> <ul style="list-style-type: none">• Submitting the appropriate forms(s) within 60 days of when your coverage would end• Paying the full cost of coverage, except Subscribers under the Legislative Retirement System• Providing a statement from your employer verifying your service

If you have this situation:	You will be affected in this way:
<p>Leave your job and:</p> <ul style="list-style-type: none"> • Have at least 10 years of service, but before minimum age to qualify for an immediate retirement annuity • You leave money in retirement system 	<p>You can continue coverage by:</p> <ul style="list-style-type: none"> • Submitting the appropriate forms(s) within 60 days of when your coverage would end • Paying the full cost of coverage until your annuity begins • Paying a lower Member premium once your annuity begins

See provisions for Eligible Retirees for more information about how coverage is affected when you leave your job and are immediately eligible to draw a retirement annuity.

In the Event of an Active Employee's Death

The benefits available to your survivors will depend on your length of service.

- When your surviving spouse receives an annuity from a qualifying retirement system, your covered survivor(s) can continue Plan coverage if your surviving spouse:
 - Elects to receive his or her benefits as an annuity (versus a lump-sum benefit)
 - Sends the Plan a Retirement/Surviving Spouse Form within 90 days after your death

Surviving children can continue coverage until they are ineligible under Plan rules. Dependents may not be added after your death.

- When your surviving spouse does not receive an annuity or when a lump-sum benefit is elected, your survivor(s) can continue coverage through COBRA

See provisions for Eligible Retirees for information on survivor coverage in the event of a retiree's death.

Continuation of Coverage

If your coverage ends under the Plan, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Member.
- A Member's Enrolled Dependent, including with respect to the Member's children, a child born to or placed for adoption with the Member during a period of continuation coverage under federal law.

- A Member's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

- A. Termination of the Member from employment with us, for any reason other than gross misconduct, or reduction of hours; or
- B. Death of the Member; or
- C. Divorce or legal separation of the Member; or
- D. Loss of eligibility by an Enrolled Dependent who is a child; or
- E. Entitlement of the Member to Medicare benefits; or
- F. The Plan Sponsor filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Member and his or her Enrolled Dependents. This is also a qualifying event for any retired Member and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Member or other Qualified Beneficiary must notify SHBP within 60 days of the Member's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Member or other Qualified Beneficiary fails to notify SHBP of these events within the 60 day period, SHBP is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Member is continuing coverage under Federal Law, the Member must notify SHBP within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from SHBP.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

Notification Requirements for Disability Determination or Change in Disability Status

The Member or other Qualified Beneficiary must notify SHBP as described under "Terminating Events for Continuation Coverage under federal law (COBRA)", subsection A. below.

The notice requirements will be satisfied by providing written notice to SHBP at the address stated in Attachment II to this Summary Plan Description. The contents of the notice must be such that SHBP is able to determine the covered employee and Qualified Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the Member or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to SHBP, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from SHBP.

The Qualified Beneficiary's initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Members who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Members are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Member qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact SHBP for additional information. The Member must contact SHBP promptly after qualifying for assistance under the Trade Act of 1974 or the

Member will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Plan will end on the earliest of the following dates:

- A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Member's employment was terminated or hours were reduced (i.e., qualifying event A.).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first

day of the month that begins more than 30 days after the date of that determination.

- B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Member, divorce or legal separation of the Member, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D.).
- C. For the Enrolled Dependents of a Member who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Member's Medicare entitlement.
- D. The date coverage terminates under the Plan for failure to make timely payment of the premium.
- E. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.).
- G. The date the entire Plan ends.

H. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.) and the retired Member dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Member's death. Terminating events B. through G. described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Member becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact SHBP for information regarding the continuation period.

Section 10:

General Legal Provisions

This section provides you with information about:

- General legal provisions concerning the Plan.

Plan Document

This Summary Plan Description presents an overview of your benefits. If there are discrepancies between the information in this SPD and DCH Board regulations or the laws of the state of Georgia, those regulations and laws will govern at all time.

Relationship with Providers

The relationships between SHBP, United HealthCare, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees; nor are they agents or employees of United HealthCare. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits for Covered Services. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Network providers are not our employees or employees of United HealthCare; nor do we have any other relationship with Network

providers such as principal agent or joint venture. Neither we nor United HealthCare are liable for any act or omission of any provider.

United HealthCare is not considered to be an employer of the SHBP for any purpose with respect to the administration or provision of benefits under this Plan.

We and the United HealthCare are solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and us is that of Plan Sponsor and employee, Dependent or other classification as defined in the Plan.

Incentives to You

Sometimes United HealthCare may offer incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact United HealthCare if you have any questions.

Interpretation of Benefits

SHBP and United HealthCare have sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and Amendments.
- Make factual determinations related to the Plan and its Benefits.

SHBP and United HealthCare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverage's or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including United HealthCare, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or United HealthCare may need additional information from you. You agree to furnish us and/or United HealthCare with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it, we may delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or United HealthCare with all information or copies of records relating to the services provided to you. We or United HealthCare have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Member's enrollment form. We and United HealthCare agree that such information and records will be considered confidential.

We and United HealthCare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, United HealthCare, and our related entities may use and transfer the

information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or United HealthCare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as SHBP.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. If you receive a Benefit payment from the Plan for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, we have the right to recover any payments made by the Plan to you. This process of recovering earlier payments is called subrogation. In case of subrogation, you may be asked to sign and deliver information or documents necessary for us to protect our right to recover Benefit payments made. You agree to provide us all assistance necessary as a condition of participation in the Plan, including cooperation and information submitted to as supplied by a workers' compensation, liability insurance carrier, and any medical benefits, no-fault insurance, or school insurance coverage that are paid or payable.

We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and Benefits we provided to you from any or all of the following:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity obligated to provide benefits or payments to you.

You agree as follows:

- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That our rights will be considered as the first priority claim against Third Parties, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions.
- To execute and deliver such documents including consent to release medical records, and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request from you.
- You will do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under the Plan.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another

person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

If you want to bring a legal action against us or United HealthCare you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or United HealthCare.

You cannot bring any legal action against us or United HealthCare for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against us or United HealthCare you must do so within three years of the date you are notified of our final decision on your appeal, or you lose any rights to bring such an action against us or United HealthCare.

Rights and Responsibilities

Your Rights as an Employee Enrolled in Plan Coverage

As an employee enrolled in Plan coverage, you have the right to:

- Have your eligible claims paid and notifications provided in a timely manner
- Receive information about the Plan and the options available to you
- Be informed of the process for filing appeals of denied claims
- Have access to Provider information
- Review your appeal file
- Examine, without charge, all documents governing the Plan at the Plan Administrator's office
- Request copies of the above documents, in writing, from the Plan Administrator (a reasonable copy fee may apply)
- Be informed by the Plan of how to continue your coverage if it would otherwise end in certain situations

Your Rights for Continuing Group Health Plan Coverage

You have the right to continue group health plan coverage if you lose Plan coverage due to a qualifying event. In this case, you may continue health care coverage for yourself, spouse or dependents; however, you or your dependents may have to pay for such coverage. Review this Summary Plan Description (SPD) and other Plan documents governing your COBRA continuation coverage rights.

Your Responsibilities as an Employee Enrolled in Plan Coverage

As an employee enrolled in Plan coverage, you can receive the most value from your coverage if you fulfill the following responsibilities:

- **Make proper and timely premium payments.** Premium payments usually are made through convenient payroll deduction. It's your responsibility to make sure that your employer (the State, school district, agency, etc.) is deducting the right amount from your paycheck for your option and coverage type. When you are first hired, and later during each Open Enrollment (or Retiree Option Change Period), you will receive premium information. If you are mailing premiums to the Plan – when you are on leave without pay, for example – your payments must be received on time at the Plan.
- **Make accurate choices when you make your enrollment selection.** After the Open Enrollment period ends, the SHBP will make changes only when there is a documented administrative error. Any premium refund will be limited to 12 months of premiums and is payable only after the Plan receives documented evidence from the Member that the Plan had no liability for additional covered persons.
- **Take the time to understand how the Plan option works.** You are the manager of your health care needs and, therefore, you must take the time to understand your Plan option. You also are responsible for understanding the consequences of your decisions. Carefully review this booklet and the *Health Plan Decision Guide*. Having read the documents, you can take steps to maximize your coverage.

- **Know when and how your participation can end.** Generally, coverage ends when you no longer meet job classification or working hours requirements for eligibility or when you fail to make the proper premium payments. For eligibility requirements and other circumstances that may result in loss of coverage, see sections 4 & 5.
- **Notify your payroll office of any address changes. Your payroll office is responsible for your address and will contact the SHBP.**
- **Notify the Plan if you have a qualifying event that can affect coverage or eligibility for coverage for you or a Covered Dependent.** If you get married, divorced or have a baby, you may want to add or delete a dependent. You must notify your payroll location within 31 days of the event – or you won't be able to make the change until the next Open Enrollment period. Retirees do not have an Open Enrollment period; failure to notify the Plan within 31 days of a qualified change in status could permanently prohibit a retiree from making the desired change.
- **Furnish the Plan with information required to implement Plan provisions.** You are required to provide any information and documentation that the Plan needs to carry out its provisions. If you do not provide the information within 31 days, your request for benefits or Plan membership will be denied. If the Plan pays benefits for a dependent who is subsequently found ineligible for coverage, or you are not able to document dependent eligibility when requested by the Plan, the Plan has the right to:
 - Terminate the dependent's coverage retroactively to his or her coverage effective date without prejudicing any other rights or remedies available to the Plan under law.
- **Update the Plan on the status of eligible dependents.** If your dependent child is nearing age 19, you are responsible for informing the Plan of his or her status within 31 days. Coverage won't continue automatically after an eligible dependent turns 19 – you must request it. You also must notify the Plan when a dependent gets married, enters the military or, when the dependent is 19 or older, graduates or stops attending school full time.
- **Notify the Plan of any other group coverage you have,** including Medicare coverage. You may be required to provide notification in advance or on request.

Your Employer's Responsibilities

Your employer – your department, agency or other entity – has specific responsibilities under the Plan, which includes the following:

- Submit any necessary documentation in a timely and efficient manner.
- Withhold proper monthly premiums and submit them, along with the bill and submit to the Plan when due. If your employer does not send in premiums and documentation in a proper and timely manner, the Plan may suspend coverage benefit payments for the Employee.
- Assist in enrolling all eligible full-time employees in the Plan within 31 days of hire unless the employee declines coverage, which then must be completed within the first 15 days on the job.
- Provide enrollment information to the Plan Administrator.

- Distribute Plan materials, including this SPD booklet, and hold group meetings to give you information about the Plan at the Plan Administrator's request.
- Administer the Family and Medical Leave Act (FMLA) in compliance with federal law.
- Provide you with information on how you can continue coverage under the FMLA and under state leave without pay provisions.
- Provide necessary termination of coverage information to the Plan Administrator within 30 days after your employment ends or your eligibility for Plan Membership ends.
- Notify enrolled employees of Plan amendments or termination.

Assistance With Your Questions

If you have any questions about your rights and responsibilities under this Plan, you should contact the Plan's Eligibility Unit at 404-656-6322 in Atlanta, or at 800-610-1863 outside of Atlanta.

Department of Community Health Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Plan's Privacy Commitment to You

The Georgia Department of Community Health (DCH) understands that information about you and your family is personal. DCH is committed to protecting your information. This notice tells you how DCH uses and discloses information about you. It tells you your rights and the Plan's requirements about your information.

Understanding the Type of Information That the Plan Has

Your employer (state agency, school system, authority, etc.) sent information about you to DCH. This information included your name, address, birth date, phone number, Social Security Number and other health insurance policies that you may have. It may also have included health information. When your health care Providers send claims to United HealthCare for payment, the claims include your diagnoses and the medical treatments you received. For some medical treatments, your health care Providers send additional medical information to the Plan such as doctor's statements, x-rays or lab test results.

Your Health Information Rights

You have the following rights regarding the health information that DCH has about you.

- You have the right to see and obtain a copy of your health information. An exception is psychotherapy notes. Another exception is information that is needed for a legal action relating to DCH.
- You have the right to ask DCH to change health information that is incorrect or incomplete. DCH may deny your request under certain circumstances.
- You have the right to request a list of the disclosures that DCH has made of your health information beginning in April 2003.
- You have the right to request a restriction on certain uses or disclosures of your health information. DCH is not required to agree with your request.
- You have the right to request that DCH communicates with you about your health in a way or at a location that will help you keep your information confidential.

- You have the right to receive a paper copy of this notice. You may ask DCH staff to give you another copy of this notice, or you may obtain a copy from DCH's Web site, www.dch.georgia.gov (click on "Privacy").

Privacy Law's Requirements

DCH is required by law to:

- Maintain the privacy of your information.
- Give you this notice of DCH's legal duties and privacy practices regarding the information that DCH has about you.
- Follow the terms of this notice.
- Not use or disclose any information about you without your written permission, except for the reasons given in this notice. You may take away your permission at any time, in writing, except for the information that DCH disclosed before you stopped your permission. If you cannot give your permission due to an emergency, DCH may release the information if it is in your best interest. DCH must notify you as soon as possible after releasing the information.

In the future, DCH may change its privacy practices. If its privacy practices change significantly, DCH will provide a new notice to you. DCH will post the new notice on its Web site at www.dch.georgia.gov (click on "Privacy"). This notice is effective April 14, 2003.

How DCH Uses and Discloses Health Care Information

There are some services the Plan provides through contracts with private companies. For example, United HealthCare pays most medical claims to your health care providers. When services are contracted, the Plan may disclose some or all of your information to the company so that they can perform the job the Plan has asked them to do. To protect your information, the Plan requires the company to safeguard your information in accordance with the law. The following categories describe different ways that the Plan uses and discloses your health information. For each category, we will explain what we mean and give an example.

For Payment: The Plan may use and disclose information about you so that it can authorize payment for the health services that you received. For example, when you receive a service covered by the Plan, your health care provider sends a claim for payment to United HealthCare.

The claim includes information that identifies you, as well as your diagnoses and treatments.

For Medical Treatment: The Plan may use or disclose information about you to ensure that you receive necessary medical treatment and services.

Operate Various Plan Programs: The Plan may use or disclose information about you to run various Plan programs and ensure that you receive quality care. For example, the Plan may contract with a company that reviews Hospital records to check on the quality of care that you received and the outcome of your care.

To Other Government Agencies Providing Benefits or Services:

The Plan may give information about you to other government agencies that are giving you benefits or services. The information must be necessary for you to receive those benefits or services.

To Keep You Informed: The Plan may mail you information about your health and well-being. Examples are information about managing a disease that you have, information about your managed care choices, and information about Prescription Drugs you are taking.

For Overseeing Health Care Providers: The Plan may disclose information about you to the government agencies that license and inspect medical facilities, such as Hospitals, as required by law.

For Research: The Plan may disclose information about you for a research project that has been approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information. The research must be for the purpose of helping the Plan.

As Required by Law: The Plan will disclose information about you as required by law.

For More Information and to Report a Problem

If you have questions and would like additional information, you may contact the SHBP at 404-656-6322 (Atlanta calling area) or 800-610-1863 (outside of Atlanta calling area). If you believe your privacy rights have been violated:

- You can file a complaint with the Plan by calling the SHBP at 404-656-6322 (Atlanta calling area) or 800-610-1863 (outside of Atlanta calling area), or by writing to: SHBP – HPU, P.O. Box 1990, Atlanta, GA 30301.

- You can file a complaint with the Health and Human Services Office for Civil Rights, Region IV, Atlanta Federal Center, 61 Forsyth Street SW, Suite 3B70, Atlanta, GA 30303-8909. Phone 404-562-7886; Fax 404-562-7884.
- You may also contact the HHS Office for Civil Rights by calling 1-866-OCR-PRIV 1-866-627-7748 or e-mail to OCR at OCRComplaint@hhs.gov.

There will be no retaliation for filing a complaint or grievance.

Section 11: Glossary of Defined Terms

This section:

- Defines the terms used throughout this SPD.
- Is not intended to describe Benefits.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by the SHBP or the UHC. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Annual Deductible - the amount you must pay for Covered Health Services in a Plan year before the SHBP will begin paying for Benefits in that Plan year.

The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. See the definition of Eligible Expenses below.

Benefits - your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any attached Riders and Amendments.

Clinical Cancer Trial Services - clinical trials study the effectiveness of new interventions. There are different types of cancer clinical trials such as:

- prevention trials;
- early detection trials;
- treatment trials to test new therapies in individuals who have cancer;
- quality of life studies;
- studies to evaluate ways of modifying cancer-causing behaviors.

Clinical trials follow strict scientific guidelines that deal with many areas such as:

- study design,
- who can be in the study,
- the kind of information individuals in the study must be given when they decide to participate.

Clinical trials follow protocols for determining:

- the number of Members;
- what drugs Members will take;
- what medical tests they will have; and
- how often and what information will be collected.

There are four phases of clinical trials. Clinical trials pilot program will include all phases of clinical trials, as long as they meet the criteria defined for the program.

Phase I Trials evaluate how a new drug should be administered and enroll only a small number of patients.

Phase II Trials provide preliminary information about how well a new drug works and generates more information about safety and benefits of the new drug or procedure.

Phase III Trials compare a promising new drug, a combination of drugs or a procedure with the current standard. This phase involves large numbers of people in doctors' offices, clinics and cancer centers. (Many of our members will be in this category). This phase utilizes a randomized process of assigning Members to the standard intervention or the trial intervention.

Phase IV Trials continue the evaluation of drugs after FDA approval and utilize drugs already on the market and available for general use.

Congenital Anomaly - a physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Coinsurance - the charge you are required to pay for certain Covered Health Services is a percentage of Eligible Expenses determined after applicable deductibles have been met.

Copayment - the charge you are required to pay for certain Covered Health Services. A Copayment is a set dollar amount that you pay at the time services are rendered.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by United HealthCare on behalf of SHBP.

Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions).

Covered Person - either the Enrolled Member or an enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person. Also referred to as "Member".

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - your eligible dependents that participates in the Plan, which can include an eligible spouse, child, full-time student or totally disabled child.

Designated Facility - a facility that has entered into an agreement on behalf of the facility and its affiliated staff with United HealthCare or with an organization contracting on its behalf to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable, except urinary catheters, ostomy supplies and disposable items that are considered an integral part of covered DME.
- Is manufactured and used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Expenses - for Covered Health Services incurred while the Plan is in effect, Eligible Expenses are determined as stated below:

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged through United HealthCare, Eligible Expenses are billed charges unless a lower amount is negotiated.

Eligible Person - The Member who may be the employee, teacher, retiree, contract employee or extended beneficiary who is eligible for Plan coverage and who has paid the necessary deduction or premium for such coverage.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Member - the contract holder who may be the Employee, retiree, Contract Employee or Extended Beneficiary and who is currently enrolled in Coverage and who has paid the necessary Deduction or Premium for such Coverage.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Full-time Student - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, occupational, specialized or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student at the end of the calendar month you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law, that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has a 24 hour nursing service.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time, as determined by the SHBP, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Lifetime Maximum Benefit - the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Plan, or any other plan of the Plan Sponsor. When the Lifetime Maximum Benefit applies, it is described in (Section 1: What's Covered--Benefits).

Medicare - Parts A, B and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Member - Refer to Enrolled Member.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Abuse Designee - the organization or individual, designated by United HealthCare, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with United HealthCare or with United HealthCare's affiliate to participate in United HealthCare's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. United HealthCare's affiliates are those entities affiliated with them through common ownership or control with United HealthCare or with its ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of United HealthCare's products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan, as determined by the SHBP.

Out-of-Pocket Maximum - the maximum amount of Annual Deductible and Copayment/Coinsurance you pay every Plan year. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that Plan year.

Copayment/Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services;
- Copayment/Coinsurance for Covered Health Services available by an optional Rider.
- Any Copayment/Coinsurance for Covered Health Services in (Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that

Benefits for services from that provider are available to you under the Plan.

Plan - Choice Plan for Georgia Department of Community Health State Health Benefit Plan.

Plan Administrator - is Georgia Department of Community Health.

Plan Sponsor - Georgia Department of Community Health. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Preventive/Routine Care - is a set of measures taken in advance of symptoms to prevent illness or injury. This type of care is best exemplified by routine physical examinations and immunizations. The emphasis is on preventing illnesses before they occur.

Qualified Medical Child Support Order (QMCSO) - Any judgment, decree, order (including approval of a settlement agreement), or National Medical Support Notice that a court of competent jurisdiction or a state agency issues. The order must provide for medical coverage for your natural child.

Rider - any attached written description of additional Covered Health Services not described in this SPD. Riders are effective only when signed by SHBP and are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

SHBP – State Health Benefit Plan.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spinal Treatment Provider - licensed Chiropractor.

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Transition of Care - Transition of care is a service that enables new enrollees to receive time limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and United HealthCare may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and United HealthCare must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Riders, Amendments, Notices

Outpatient Prescription Drug Rider

Attachment I

Choice Plan

**Outpatient
Prescription Drug Rider**

Outpatient Prescription Drug Rider

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Outpatient Prescription Drug Rider

This Rider to the Summary Plan Description provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 11: Glossary of Defined Terms) of the Summary Plan Description and in (Section 3: Glossary of Defined Terms) of this Rider. When we use the words "we," "us," and "our" in this document, we are referring to Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Summary Plan Description (Section 11: Glossary of Defined Terms).

NOTE: The Coordination of Benefits provision (Section 7: Coordination of Benefits) in the Summary Plan Description does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will be coordinated with those of any other health coverage plan as described under “Coordination of Benefits (COB)” section, page 9.

Introduction

Benefits for Outpatient Prescription Drug Products

United HealthCare administers your pharmacy benefit program. United HealthCare uses Medco Health Solutions, Inc. (Medco) for certain pharmacy administrative services such as claims processing and customer care.

This rider will cover a detailed description about your prescription drug plan, including: prescription drug list; quantity level limits; notification (prior authorizations); maintenance medications; covered medications; non-covered medications; definitions of brand name medications and generic medications; and the Progression Rx program.

Benefits are available for outpatient Prescription Drug Products on the Prescription Drug List (which meet the definition of a Covered Health Service) at a Network Pharmacy is subject to Copayment or other payments that vary depending on which of the three tiers of the Prescription Drug List the outpatient Prescription Drug are listed.

Please note: For the most up to date coverage information (including supply limits, specific notification requirements, etc.) for Prescription Drug Products that meet the definition of a Covered Health Service, you may call the customer care number on the back of your State Health Benefit Plan ID card.

Coverage Policies and Guidelines

Your United HealthCare pharmacy benefit provides coverage for a comprehensive selection of prescription medications governed by a Prescription Drug List (PDL)

A Prescription Drug List (PDL) is a list of Food and Drug Administration (FDA)-approved brand name and generic medications.

Prescription medications are categorized within three tiers. Each tier is assigned a copayment, the amount you pay when you fill a prescription, which is determined by your health plan.

Several factors are considered when deciding the placement of a medication on the UHC Prescription Drug List including the medication's classification. Several committees contribute and evaluate the overall value of the medication to ensure an unbiased approach. Committee members are various health care professionals including pharmacists and physicians with a broad range of specialties.

The two main committees are:

Our National Pharmacy and Therapeutics (P&T) Committee evaluates clinical evidence in order to determine a medication's role in therapy and its overall clinical value. In addition, the P&T Committee reviews the relative safety and efficacy of the medication.

The United HealthCare PDL Management Committee evaluates the clinical recommendations of the P&T committee as well as pharmacoeconomic and economic information. Once a medication's clinical, pharmacoeconomic and economic value is established, our PDL Management Committee makes a tier placement decision based on the overall value of the medication.

The PDL Management Committee helps to ensure access to a wide range of affordable medications for you.

United HealthCare may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per Plan year. These changes may occur without prior notice to you.

Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet, or call the Customer Care number on your ID card for the most up-to-date tier status. **Tier status and Copayments will not be overridden or changed on an individual basis.**

Identification Card (ID Card) - Network Pharmacy

In order to utilize your prescription drug benefit at a Network Pharmacy, you must show your State Health Benefit Plan ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy. If you forget your ID card, you must provide the Network Pharmacy with identifying information that can be verified during regular business hours.

If you do not show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the Pharmacy.

You may seek reimbursement from us as described in Summary Plan Description (Section 6: How to File a Claim). When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when purchasing the Prescription Drug Product. The amount you are reimbursed will be based on the Network Pharmacy's contracted Prescription Drug Cost, less the required Copayment and an Ancillary Charge if applicable.

Designated Pharmacies

If you require certain Prescription Drug Products, United HealthCare may direct you to a Designated Pharmacy with whom they have an exclusive arrangement to provide those Prescription Drug Products.

In this case, Benefits will only be paid if your Prescription is obtained from the Designated Pharmacy.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Member Rights and Responsibilities

As a member, you have the right to express concerns about your State Health Benefit Plan coverage and to expect an unbiased resolution of your individual issues. You have the right to submit a written appeal or inquiry regarding any concern that you may have about the Prescription Drug Program or your drug coverage.

Pharmacy Services:
1-866-527-9599

Written appeals and inquiries related to the Prescription Drug Program should be directed to:

State of Georgia - State Health Benefit Plan Members
10200 Old Columbia Road, Suite M/N
Columbia, MD 21046

Attn: Appeal/Inquiry Unit

United HealthCare Disclaimer

This Summary Plan Description (SPD) summarizes the State Health Benefit Plan Prescription Drug Program. It is not intended to cover all details related to your prescription drug coverage under the State Health Benefit Plan. This Summary Plan Description (SPD) is not a contract and the benefits that are described can be terminated or amended by the State Health Benefit Plan according to applicable laws, rules, and regulations. Should any conflicts arise between this booklet and your official plan documents, the official plan documents will govern.

Section 1: What's Covered-- Prescription Drug Benefits

We provide Benefits under the Plan for outpatient Prescription Drug Products:

- Designated as covered at the time the prescription is dispensed when obtained from a Network Pharmacy.
- Refer to exclusions in your Summary Plan Description (Section 2: What's Not Covered--Exclusions) and as listed in Section 2 of this Rider.

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service.

When a Brand-name Drug Becomes Available as a Generic

When a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment may change. You will pay the Copayment applicable for the tier to which the Prescription Drug Product is assigned unless you request a brand name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (generic equivalent). If you request a brand name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (generic equivalent) you will pay the applicable Copayment in addition to the Ancillary Charges.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits (also known as quantity limits) based on criteria that United HealthCare has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription and/or the amount dispensed per month's supply.

You may determine a maximum quantity level for dispensing for a Prescription Drug Product through the Internet at www.myuhc.com or by consulting your Prescription Drug List or by calling Customer Care at the telephone number on your ID card.

Notification (also known as Prior Authorization or Coverage Review) Requirements

Before certain Prescription Drug Products are covered by your Plan and dispensed to you, your Physician, your pharmacist or you are required to notify United HealthCare or its designee. The reason for notification is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- Meets the definition of a Covered Health Service.
- It is not Experimental, Investigational or Unproven.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying United HealthCare. It is important to make sure United HealthCare is notified and approval for coverage is obtained before going to the pharmacy.

The Prescription Drug Products requiring notification are subject to periodic review and modification.

You may determine whether a particular Prescription Drug Product requires notification by consulting your Prescription Drug List or through the Internet at www.myuhc.com or by calling the Customer Care number on your ID card.

If United HealthCare is not notified before the Prescription Drug Product is dispensed, you will be required to pay full price for that prescription at the pharmacy.

If United HealthCare is notified after you pay full price and the Notification is approved, you may request reimbursement from us as described in the Summary Plan Description (Section 6: How to File a Claim). Please note the amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment, and Ancillary charge that applies.

You may obtain a prescription drug claim form from Medco by calling the Customer Care number on your State Health Benefit Plan ID card or through the Internet at www.myuhc.com. The Medco claim form is also available in electronic format on the Department of Community Health web site: www.dch.georgia.gov. You may print a copy of the Medco claim form from this web site. Along with the prescription drug claim form you will need a receipt for your prescription.

When you submit a claim on this basis, you may pay more because you did not notify United HealthCare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment, Ancillary Charge that applies.

Benefits may not be available for the Prescription Drug Product after the documentation provided is reviewed and it is determined that the Prescription Drug Product is not a Covered Health Service or it is Experimental, Investigational or Unproven.

Progression Rx Program Requirements

Before certain Prescription Drug Products are dispensed, you may be required to try an alternative medication, which has been determined to be safe, effective, and less costly before receiving a brand name Prescription Drug Product.

Generic drugs are usually in the first step. Tested and approved by the U.S. Food & Drug Administration (FDA), the generics provided by your plan are effective for treating many medical conditions. This first step lets you begin or continue treatment with prescription drugs that may have a lower copayment.

Brand-name drugs are usually in the second step. If your treatment requires different medications, then the program moves you along to this next step. Brand-name drugs may have a higher copayment.

When you submit a prescription that is not for a first step drug, you, your Physician or your pharmacist are required to notify United HealthCare. You can call the Customer Care number on your ID card to obtain options of safe, effective first step drugs to discuss with your physician.

You may determine whether a particular Prescription Drug Product is part of the Progression Rx Program by consulting your Prescription Drug List or through the Internet at www.myuhc.com or by calling the Customer Care number on your ID card.

Clinical Appeal Process

If a notification, quantity limitation, and/ or Progression Rx request is denied by Medco, you or your physician may initiate the clinical appeals process.

Please be informed that we recommend a physician initiate an appeal for a denied Notification decision by United HealthCare so that all necessary clinical information can be obtained.

The physician's request/appeal must be submitted in writing (via letter) to us for consideration. A physician must submit an appeal within 180 calendar days of the date of the denial letter. This is known as the first-level appeal. The written inquiry should be directed to:

State of Georgia - State Health Benefit Plan Members
10200 Old Columbia Road, Suite M/N
Columbia, MD 21046

Attn: Appeal/Inquiry Unit

United HealthCare will advise the physician and the member, in writing, of its decision. If United HealthCare upholds the denial, information regarding the second-level appeal process will be provided to the physician and the member.

Second-level appeals (an appeal to the first-level appeal decision described above) must be initiated by a physician and, must be received in writing (via letter). The second level appeal must be submitted within 60 days of the date of the first level appeal denial letter.

The second-level appeal request, along with any new and/or additional supporting documentation should be forwarded to United HealthCare to the address above. **The second level appeal decision is the final decision.**

If a final determination to deny Benefits is made, you may choose to participate in our voluntary external review program, at your cost. The cost can range from \$500-\$2,000. This program only applies if the decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental, Investigational or Unproven Services.

NOTE: The external review program is not available if the coverage determinations are based on explicit Benefit exclusions or defined Benefit limits. Therefore, the second level appeal decision is final.

Contact United HealthCare at the telephone number shown on your ID card for more information on the voluntary external review program.

How to Fill Your Prescription At A Non-Participating Pharmacy

When you use a non-participating pharmacy, you must pay the full retail cost for your prescription and then submit a claim form to Medco for reimbursement of covered drug costs. Assignment of Benefits (AOB) is not available except for military facilities such as Veterans' Administration hospitals, army bases, etc.

You may obtain a claim form from Medco by calling the Customer Care number on your State Health Benefit Plan ID card or through the Internet at www.myuhc.com. The Medco claim form is also available in electronic format on the Department of Community Health web site: www.dch.georgia.gov. You may print a copy of the Medco claim form from this web site. Along with the prescription drug claim form you will need a receipt for your prescription.

The prescription drug claim form must be filled out in its entirety. Any missing information may cause a delay in processing your reimbursement. Required information includes the pharmacy seven digit NCPDP number (this number should be identified on your pharmacy receipt), the National Drug Code (NDC) number for your prescription (this can be obtained from your pharmacy), the prescription number, the name of the pharmacy, the physician's name, the member ID number, the patient's name, and the patient's date of birth. A pharmacy receipt is also required with the claim form.

You will have 24 months from the date that your prescription was filled to submit your pharmacy receipt and claim form to receive reimbursement for covered drugs. You must submit your pharmacy receipt and claim form to the address identified on the claim form. You will be reimbursed the Prescription Drug Cost less the applicable Copayment and any Ancillary Charges if applicable. Also, you are subject to benefit plan rules (including but not limited to Notification and Progression Rx) as well as balance billing if the charged amount exceeds the network cost of your prescription(s).

Coordination of Benefits (COB)

If your spouse or a dependent has primary coverage from another health plan, prescription drug benefits provided by the State Health Benefit Plan (SHBP) will be coordinated with the other insurance carrier(s). This means you must first use your primary insurance plan when you pay for your prescription(s). To request a secondary payment from Medco at the time of purchase you can request the Pharmacist to electronically file SHBP secondary. By mail you can send a Medco prescription claim form and attach a copy of the Explanation of Benefits (EOB) form from the primary plan or the pharmacy receipt. You can obtain a copy of the Medco claim form at www.myuhc.com/groups/gdch, www.dch.georgia.gov. or at www.myuhc.com.

When the SHBP is the Secondary Plan, benefits are coordinated to pay only the difference between the amount paid by the Primary Plan and the allowable amount payable by the SHBP, less any applicable co-payments or coinsurance. Please note the amount paid will not exceed the allowable amount payable by the SHBP, less any applicable co-payments or coinsurance.

Please contact Medco at the Customer Care number on your State Health Benefit Plan ID card for more details.

If you have coverage under two State Health Benefit Plan contracts (cross-coverage) prescription drug benefits provided by the State Health Benefit Plan will not be coordinated. A copayment will be required for each filled prescription.

What You Must Pay

You are responsible for paying the applicable Copayment described in the Benefit Information table, in addition to any Ancillary Charge when Prescription Drug Products are obtained from a retail pharmacy.

The Ancillary Charge applies when you request the Pharmacist to dispense a brand name drug when a generic equivalent at a lower copayment level exists.

The amount you pay for any of the following under this Rider will not be included in calculating **any Out-of-Pocket Maximum stated in your Summary Plan Description**:

- Copayment for Prescription Drug Products
- Ancillary Charges.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.

Payment Information

Payment Term	Description	Amounts
Copayment	<p>Copayment for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount or a percentage of the Prescription Drug Cost.</p> <p>Your Copayment is determined by the tier to which United HealthCare's Prescription Drug List Management Committee has assigned a Prescription Drug Product.</p> <p>NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per Plan year, based on United HealthCare's Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, your Copayment may change. Please access www.myuhc.com through the Internet, or call the Customer Care number on your ID card for the most up-to-date tier status.</p> <p>Tier Status and Copayments will not be overridden or changed on an individual basis.</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:</p> <ul style="list-style-type: none"> • The applicable Copayment or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. <p><i>See the Copayment stated in the Benefit Information table for amounts.</i></p>

Benefit Information

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
<p data-bbox="157 316 1008 414">Prescription Drugs from a Retail Network Pharmacy</p> <p data-bbox="157 422 1134 487">Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply:</p> <ul data-bbox="157 519 1176 706" style="list-style-type: none">• As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.• As written by the provider, Copayment amount for up to a consecutive 90-day supply of a Maintenance Drug Product.	<p data-bbox="1228 316 1953 633">Your Copayment is determined by the tier to which United HealthCare's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please consult your PDL or access www.myuhc.com through the Internet, or call the Customer Care number on your ID card to determine tier status.</p> <p data-bbox="1228 665 1627 698">Coverage up to 31-day supply:</p> <p data-bbox="1228 722 1879 787">\$10 per Prescription for a Tier-1 Prescription Drug Product.</p> <p data-bbox="1228 828 1879 893">\$30 per Prescription for a Tier-2 Prescription Drug Product.</p> <p data-bbox="1228 925 1879 990">\$75 per Prescription for a Tier-3 Prescription Drug Product.</p> <p data-bbox="1228 1023 1900 1128">* If the Usual or Customary price or the Network Pharmacy discounted price is less than the Copayment, you will pay the lesser amount.</p> <p data-bbox="1228 1153 1921 1323">If you request a brand name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (generic equivalent) you will pay the applicable Copayment in addition to Ancillary Charges.</p>

Maintenance Prescription Drugs from a Retail Network Pharmacy

Maintenance Prescription Drug products are medications taken on an ongoing basis for the treatment of chronic conditions such as diabetes, ulcers or high blood pressure. You may obtain up to a 90-day supply if your physician writes a prescription for a 90 day supply (for example if you take 2 tablets a day, your physician must write a prescription for a quantity of 180 tablets to be dispensed).

Maintenance medications include, but are not limited to:

- Anti-Parkinson medications;
- Asthma medications that are taken orally, excluding inhalers;
- Cardiovascular medications for hypertension and heart disease;
- Diabetic medications;
- Estrogen and Progestin medication;
- Medications for the treatment of epilepsy;
- Medications for the treatment of multiple sclerosis
- Oral Contraceptives and;
- Thyroid medications.

You will be charged two copayments per 90-day supply. Please call the Customer Care number if you have specific questions regarding whether or not a medication is covered as a maintenance medication.

Your Copayment is determined by the tier to which United HealthCare's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please consult your PDL or access www.myuhc.com through the Internet, or call the Customer Care number on your ID card to determine tier status.

Coverage for 32 day up to 90-day supply:

\$20 per Prescription for a **Tier-1 Prescription Drug Product.**

\$60 per Prescription for a **Tier-2 Prescription Drug Product.**

\$150 per Prescription for a **Tier-3 Prescription Drug Product.**

***If the Usual or Customary price or the Network Pharmacy discounted price is less than the Copayment, you will pay the lesser amount.**

If you request a brand name Prescription Drug Product in place of the chemically equivalent Prescription Drug Product (generic equivalent) you will pay the applicable Copayment in addition to Ancillary Charges.

Section 2: What's Not Covered-- Exclusions

Exclusions from coverage listed in the Summary Plan Description apply also to this Rider. In addition, the following exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
3. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
3. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in transitional living programs, day treatment programs related to senior/adult care treatment, assisted living, non-skilled assisted care, nursing homes, personal care homes, extended care facilities, cognitive remediation therapy.
4. Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by United HealthCare to be experimental, investigational or unproven.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
7. Any product dispensed for the purpose of appetite suppression and other weight loss products.
8. An injectable medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by United HealthCare, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Gardasil and Zostavax vaccines and self-administered injectable medications covered through your pharmacy benefit plan.
9. The cost of labor and/ additional charges for compounding prescriptions excluding contractual dispensing fees that pharmacies charge.
10. Charges for the administration or injection of any Prescription Drug Product.
11. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
12. General vitamins, except the following which require a prescription: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
13. Unit dose packaging of Prescription Drug Products.
14. Medications used for cosmetic purposes.

15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
17. Prescription Drug Products when prescribed to treat infertility.
18. Prescription Drug Products for smoking cessation.
19. Prescription and over-the-counter contraceptive jellies, creams, foams, devices and implants.
20. Yohimbine.
21. Mifeprex.
22. Blood or blood plasma product.
23. Compounded drugs that do not contain at least one ingredient that requires a prescription. (Compounded drugs that contain at least one ingredient that requires a prescription will be assigned to Tier-3.)
24. Drugs available over-the-counter that do not require a prescription by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
25. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by United HealthCare's Prescription Drug List Management Committee.
26. Mail Order Drugs.

Section 3: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Rider. Other defined terms used throughout this Rider can be found in (Section 11: Glossary of Defined Terms) of your Summary Plan Description.
- Is not intended to describe Benefits.

Ancillary Charge - a charge, in addition to the Copayment, that you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a chemically equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Cost or MAC list price for Network Pharmacies for the brand name Prescription Drug Product on the higher tier, and the Prescription Drug Cost or MAC list price of the chemically equivalent Prescription Drug Product available on the lower tier.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that United HealthCare identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by United HealthCare.

Designated Pharmacy - a pharmacy that has entered into an agreement on behalf of the pharmacy with United HealthCare or with an organization contracting on its behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that United HealthCare identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by United HealthCare.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that United HealthCare establishes. This list is subject to periodic review and modification.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with United HealthCare or its designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by United HealthCare as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following dates:

- The date it is assigned to a tier by United HealthCare's Prescription Drug List Management Committee.
- December 31st of the following Plan year.

Prescription Drug Cost - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that identifies those Prescription Drug Products for which Benefits are available under this Rider. This list is subject to periodic review and modification (generally quarterly, but no more than six times per Plan year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling the Customer Care number on your ID card.

Prescription Drug List Management Committee – the committee that United HealthCare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices;
 - glucose monitors.

Usual and Customary Charge - The amount that a pharmacist would charge a cash-paying customer for a prescription.

- End of Outpatient Prescription Drug Rider -

Section 4: Frequently Asked Questions

This section:

- Help you understand your medication choices and make informed decisions.
- Help you understand which questions to ask your doctor or pharmacist.

What is a Prescription Drug List (PDL)?

A PDL is a list of Food and Drug Administration (FDA) approved brand name and generic medications.

The UHC Prescription Drug List (PDL) is one way you can find out the tier status and specific rules linked to your medication. The PDL lists the most commonly prescribed medications for certain conditions.

The PDL offers a wide choice of brand name and generic medications that are reviewed by doctors and pharmacists on our various committees. The list is updated to reflect decisions based on new medical evidence and information. Additionally, the United States Food and Drug Administration (FDA) approves all medications, including generics, which means you can be confident that whatever medication you choose, it meets the strict guidelines set by the FDA.

Your United HealthCare pharmacy benefit provides coverage for a comprehensive selection of prescription medications. You can check which medications are on which tiers at www.myuhc.com. You and your doctor may refer to this list to consider prescription medication choices and select the appropriate medication to meet your needs.

Understanding Tiers

Prescription medications are categorized within three tiers. Each tier is assigned a copayment, the amount you pay when you fill a prescription, which is determined by your health plan. Consult your benefit plan documents to find out the specific copayments that are part of your plan. You and your doctor decide which medication is appropriate for you.

Tier 1 Your Lowest-Cost Option	Tier 2 Your Midrange-Cost Option	Tier 3 Your Highest-Cost Option
This is your lowest copayment option. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your doctor decide they are right for your treatment.	This is your middle copayment option. Consider Tier 2 medications if you and your doctor decide that a Tier 2 medication is right for your treatment.	This is your highest copayment option. Sometimes there are alternatives available in Tier 1 or Tier 2 that may be appropriate to treat your condition. If you are currently taking a medication in Tier 3, ask your doctor whether there are Tier 1 or Tier 2 alternatives that may be right for your treatment.

Tier 1 Your Lowest-Cost Option	Tier 2 Your Midrange-Cost Option	Tier 3 Your Highest-Cost Option
		Compounded medications, medications with one or more ingredients that are prepared “on-site” by a pharmacist, are classified at the Tier 3 level.

What factors are looked at for tier placement decisions and who decides which medications get placed in which tier ?

Several factors are considered when deciding the placement of a medication on the UHC Prescription Drug List including the medication’s classification. Several committees contribute and evaluate the overall value of the medication to ensure an unbiased approach. Committee members are various health care professionals including pharmacists and physicians with a broad range of specialties.

The two main committees are:

Our National Pharmacy and Therapeutics (P&T) Committee evaluates clinical evidence in order to determine a medication’s role in therapy and its overall clinical value. In addition, the P&T Committee reviews the relative safety and efficacy of the medication.

The United HealthCare PDL Management Committee evaluates the clinical recommendations of the P&T committee as well as pharmacoeconomic and economic information. Once a medication’s clinical, pharmacoeconomic and economic value is established, our PDL Management Committee makes a tier placement decision based on the overall value of the medication.

The PDL Management Committee helps to ensure access to a wide range of affordable medications for you.

How often will prescription medications change tiers?

Medications may move to a higher tier one time per calendar year on January 1. Additionally, when a brand name medication becomes available as a generic, the tier status of the brand name medication and its corresponding generic will be evaluated. When a medication changes tiers, you may be required to pay more or less for that medication. These changes may occur without prior notice to you. For the most current information on your pharmacy coverage, please call our Customer Care number on your ID card or visit www.myuhc.com.

What is the difference between brand name and generic medications?

Generic medications contain the same active ingredients as brand name medications, but they often cost less. Generic medications become available after the patent on the brand name medication expires. At that time, other companies are permitted to manufacture an FDA-approved, chemically equivalent medication. Many companies that make brand name medications also produce and market generic medications.

The next time your doctor gives you a prescription for a brand name medication, ask if a generic equivalent is available and if it might be appropriate for you. While there are exceptions, generic medications are usually your lowest cost option. Please note that some generic medications may be in Tier 2 or Tier 3 and will not have the lowest copayment available under your pharmacy benefit plan. Go to www.myuhc.com to determine the copayment for your generic medication.

Why are generic medications in tier 2 and tier 3?

Several factors are considered when deciding the placement of a medication on the UHC Prescription Drug List (PDL) including the medication's classification. Several committees contribute and evaluate the overall value of the medication to ensure an unbiased approach. Committee members are various health care professionals including pharmacists and physicians with a broad range of specialties.

For our approach to PDL management is unique for our HMO plan and differs from standard prescription drug lists. Generics are not automatically placed in the lowest copay tier and brand-name

medications in higher copay tiers. This is because in some cases generic medications may offer less value because they have a higher total net cost than the brand name medication.

The following considerations are taken into account when placing generic medications in Tier 2 or Tier 3:

- In instances where multiple generic medications are available in the same therapeutic class, there may be differences in health care value between those medications. Such differences can be clinical efficacy, potency, or cost – giving some generics greater total health care value than others.
- In some instances, generic medications may be extremely costly when first released to the market – far exceeding the norm for generic medications – and thus merit greater cost sharing from the member. As more manufactures produce the same generic medication the price becomes less expensive thereby increasing the generic's overall value and support moving the generic to Tier 1.
- In some instances, brand-name medications have a lower net cost than their generic equivalents due to our contract with the manufacturers.

The ability to place both generic and brand-name medications in any tier, as well as the ability to make periodic changes to the PDL, allows us to react quickly to market conditions, which helps us to keep medications affordable for you and SHBP.

Why is the medication that I am currently taking no longer covered?

Medications may be excluded from coverage under your pharmacy benefit. For example, a prescription medication may be excluded from coverage when it is therapeutically equivalent to an over-the-counter medication. For possible coverage alternative, please call the Customer Care number on your ID card.

When should I consider discussing over-the-counter or non-prescription medications with my doctor?

An over-the-counter medication can be an appropriate treatment for many conditions. Consult your doctor about over-the-counter alternatives to treat your condition. These medications are not covered under your pharmacy benefit, but they may cost less than your out-of-pocket expense for prescription medications.

What is a maintenance medication program?

Maintenance Prescription Drug products are medications taken on an ongoing basis for the treatment of chronic conditions such as diabetes, ulcers or high blood pressure. Maintenance medications are those prescribed medications that a member may obtain for a period of up to 90 days.

You may obtain up to a 90-day supply if your physician writes a prescription for a 90 day supply (for example if you take 2 tablets a day, your physician must write a prescription for a quantity of 180 tablets to be dispensed). You will be charged one copayment per 31-day supply.

Please call the Customer Care number if you have specific questions regarding whether or not a medication is covered as a maintenance medication.

Certain medications have been categorized as maintenance medications.

What maintenance medications are included in the maintenance medication program?

Maintenance medications include, but are not limited to:

- Anti-Parkinson medications;
- Asthma medications that are taken orally, excluding inhalers;
- Cardiovascular medications for hypertension and heart disease;
- Diabetic medications;
- Estrogen and Progestin medication;
- Medications for the treatment of epilepsy;
- Medications for the treatment of multiple sclerosis;
- Oral Contraceptives and;
- Thyroid medications.

Please call your Customer Care number on your ID card if you have specific questions regarding whether or not a medication is covered as a maintenance medication.

What are the Quantity Level Limits (QLL) and Quantity per Duration (QD) programs?

The QLL program defines the maximum quantity of medication that is covered for one prescription or copayment. The QD program defines the maximum quantity of medication that can be covered in a specified time period. QLLs and QDs are based upon the manufacturer's package size, dosing recommendations or guidelines that are included in the FDA labeling, and medical literature and guidelines.

How do the QLL and QD programs work?

If your prescription exceeds the QLL or QD limit, your pharmacist will be notified of the quantity covered for one copayment. You will have the following options:

- Accept the established quantity limit
- Pay additional out-of-pocket costs or copayments for amounts that exceed the quantity limits (as appropriate)
- Discuss alternatives with your doctor before deciding whether to fill the prescription
- Request coverage authorization for the additional amounts through the coverage review process (when available)

What is the Notification program?

Notification (also known as prior authorization or coverage review) is a set of clinical rules designed to support the pharmacy benefit at the time the prescription is dispensed. Applied to a very limited number of medications, Notification requires your doctor to provide additional information to determine whether the use of the medication is covered by your pharmacy benefit.

How does the Notification program work?

If your medication is included in the Notification program, your pharmacy is sent a message on the computer system with instructions to have your doctor call a toll-free number to get approval for the prescription. Some pharmacists will contact your doctor while others may request you do so. Your doctor will provide United HealthCare with information to determine if the prescription meets the coverage conditions of your pharmacy benefit. We will review the information and approve or deny coverage. We will send letters to you and your doctor explaining the decision and providing instructions on how to appeal if you so desire.

What should I do if I use a self-administered injectable medication?

You may have coverage for self-administered injectable medications through your pharmacy benefit plan or under your medical benefits.

Please call our Customer Care number on your ID card to determine whether or not a medication is covered as a self-administered injectable under your pharmacy or medical benefits.

How do I obtain a supply of my medications before I go on vacation?

Each plan year (calendar year), you are allowed to obtain up to a 6 months supply for each prescription.

If you would like to obtain a supply of medication prior to leaving for your vacation, you will need to inform your local network pharmacist. Your pharmacist should know how to process your vacation request however if not please have your pharmacist contact the Medco pharmacy helpdesk at (800) 922-1557.

You may also locate a network pharmacy at your vacation destination by calling our Customer Care number on your ID card or visit www.myuhc.com.

How do I access updated information about my pharmacy benefit?

Since the PDL may change periodically, we encourage you to visit www.myuhc.com or please call our Customer Care number on your ID card for more current information.

Log on to www.myuhc.com for the following pharmacy resources and tools:

- Pharmacy benefit and coverage information
- Specific copayment amounts for prescription medications
- Possible lower-cost medication alternatives
- A list of medications based on a specific medical condition
- Medication interactions and side effects, etc.
- Locate a participating retail pharmacy by zip code
- Review your prescription history

What if I still have questions?

Please call our Customer Care number on your ID card.

Representatives are available to assist you 24 hours a day, except Thanksgiving and Christmas.

Attachment I

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayment and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

